BENEFITS OVERVIEW

Prepared by Kraus-Anderson Insurance

PLAN YEAR: 2025

Address
6758 Bailey Road,
Woodbury, MN 55129

Phone
Main: 651-459-4121

Online
Website: www.newlifeacademy.org

WELCOME NOTE

At New Life Academy, we are committed to providing you with a comprehensive employee benefits program that helps our employees stay healthy, feel secure, and maintain a work and life balance.

PLAN YEAR July 1, 2025 through June 31, 2026

EXISTING EMPLOYEES – DURING ANNUAL OPEN ENROLLMENT

Please review the benefit materials provided here and make your coverage elections during your scheduled open enrollment period.

NEWLY HIRED EMPLOYEES – DURING YOUR INITIAL BENEFITS ELIGIBILITY PERIOD

As part of your on-boarding process you'll need to select your benefits. You must enroll online during this time in order to receive benefits.

EMPLOYEE ELIGIBILITY

- You are scheduled to work 30 hours per week
- Coverage goes into effect on the first day of the month following date of hire

ELIGIBLE DEPENDENTS

- Your legally married spouse
- Your child(ren) up to age 26

CHANGES DURING THE YEAR - QUALIFYING LIFE EVENTS

IRS regulations restrict your ability to change your benefit elections during the year unless you experience a qualifying life event such as:

- Marriage
- Divorce
- Birth or adoption of a child
- Death of a dependent
- Changes in your or your spouse's employment status
- Losing coverage from parent's plan at age 26
- An involuntary loss of coverage under another plan

You have **30 days** from the date of the qualifying event to make changes to your coverage, and the change has to be consistent with the qualifying life event. Be sure to notify your plan administrator, then you will be provided the opportunity to make your changes. You can make changes to your HSA contributions at any time during the year—you just can't exceed the IRS annual limits.

CONTACTS

	INSURANCE CARRIER	CARRIER INFORMATION	PLAN INFORMATION
	MEDICAL: BlueCross BlueShield of Minnesota	651-662-8000 www.bluecrossmnonline.com Click here to find provider	Group Number: 300451 Network: Aware & High Value
	PHARMACY: BlueCross BlueShield of Minnesota	651-662-8000 www.bluecrossmnonline.com Click here to find pharmacy	
	HEALTH SAVINGS ACCOUNT (HSA): Associated Bank	800-236-8866 www.associatedbank.com Register here	Group Number: TBD
	HEALTH REIMBURSEMENT ARRANGEMENT (HRA): Associated Bank	800-236-8866 www.associatedbank.com Register here	Group Number: TBD
	TELE-MEDICINE: Nice Healthcare	763-412-1993 support@nice.healthcare www.nice.healthcare	
	DENTAL: Principal	800-986-3343 www.principal.com Click here to find provider	Group Number: 1113539
	VISION: Principal	800-986-3343 www.principal.com Click here to find provider	Group Number: 1113539
	LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D): Principal	800-986-3343 www.principal.com Click here to find provider	Group Number: 1113539
	LONG-TERM DISABILITY: Principal	800-986-3343 www.principal.com Click here to find provider	Group Number: 1113539
	PLAN ADMINISTRATOR: Katie Mellett	651-757-4166	katiemellett@newlifeacademy.org

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Benefits Summary and the plan documents, the plan document will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996.

MEDICAL

Plan Options	BlueCross BlueShield MN $4,500-0% HSA Aware Plan		BlueCross BlueShield MN $4,500-0% HSA High Value Plan	
	Individual	Family	Individual	Family
Deductible Calendar Year	$4,500	$9,000	$4,500	$9,000
Preventive Care www.healthcare.gov for covered screenings	No charge		No charge	
Coinsurance	0% after deductible		0% after deductible	
Out of Pocket Maximum	$4,500	$9,000	$4,500	$9,000
Office Visit	0% after deductible		0% after deductible	
Prescription Drug Coverage	0% after deductible		0% after deductible	
	CVS / Target pharmacies are not in-network with BlueCross BlueShield MN. Check member services for pharmacies within your network			
Plan Cost	**Total Monthly Premium**	**Employee Monthly Premium**	**Total Monthly Premium**	**Employee Monthly Premium**
Employee	$591.71	$135.55	$546.16	$90.00
Employee + Spouse	$1,597.64	$365.00	$1,474.64	$242.00
Employee + Child(ren)	$1,360.96	$310.77	$1,256.196	$206.00
Family	$2,011.85	$459.88	$1,856.97	$305.00

Refer to the carrier Summary Benefits of Coverage (SBC) for specific details.

HEALTH SAVINGS ACCOUNT (HSA)

2025 Maximum Contributions	2026 Maximum Contributions
Individual: $4,300 per calendar year	Individual: $4,300 per calendar year
Family: $8,550 per calendar year	Family: $8,550 per calendar year
55+ may contribute an additional $1,000 per calendar year	
Eligible Expenses: Please refer to section 213(d) of the Internal Revenue Code, can be found at www.irs.gov	

HEALTH REIMBURSEMENT ACCOUNT (HRA)

	Single	Family
	Health Plan Pays 100%	Health Plan Pays 100%
Max Out-of-Pocket	$4,500	$9,000
Employee Responsibility	Employee responsible for first $2,500 of deductible expense. NLA contributes $500 to each individual HSA account.	Employee responsible for first $4,000 of deductible expense. NLA contributes $1,000 to each family HSA account.
HRA Reimburses	HRA (employer money) reimburses $2,501 to $4,500 of eligible expenses after employee submits documentation to a total of $2,000.	HRA (employer money) reimburses $4,001 to $9,000 of eligible expenses after employee submits documentation to a total of $5,000.
Employee and Employer Total Contributions	Employee: $2,500 Employer: $2,000	Employee: $4,000 Employer: $5,000
Eligible Expenses: Please refer to section 213(d) of the Internal Revenue Code, can be found at www.irs.gov		

TELE-MEDICINE – NICE HEALTHCARE

- Employer contributes 100% of the premium
- Virtual chat and video visits
- In-home visits with lab and testing options
- Virtual physical therapy
- Virtual mental health visits
- In-home X-ray and EKG services
- 550+ Free medications can be prescribed by our clinicians

DENTAL

Employer contributes to the employee's monthly premiums. Eligible dependents may participate in the plan and those costs are the responsibility of the employee.

Dental	Principal	
Network	**In Network**	**Out of Network**
Individual Deductible	$0	$50
Family Deductible	$0	$150
Annual Maximum (per person)	$2,000	
Preventive Services	100%	80%
Basic Services	80%	50%
Major Services	50%	50%
Orthodontia Services (dependent children ages 8-18)	50% to $1,000 Lifetime Maximum	
Plan Cost	**Total Monthly Premium**	**Employee Monthly Premium**
Employee Only	$53.24	$6.94
Employee + 1	$101.18	$13.19
Family	$159.75	$20.87

Refer to the carrier summary for specific details.

VISION

Coverage is voluntary and 100% paid by the employee

Vision	Principal (In-Network)
Eye Examinations (every 12 months)	$10 copay
Frames (every 24 months)	$150 allowance + 20% off remaining balance
Lenses (every 12 months)	$25 copay
Contacts (every 12 months)	Elective: $150 allowance + 20% off remaining balance Necessary: $25 copay
Laser Vision Correction	Up to 15% retail discount
Members can receive benefit for either glasses OR contacts in a 12-month period, not both.	
Plan Cost	**Total Monthly Premium**
Employee Only	$5.72
Employee + Spouse	$11.45
Employee + Child(ren)	$12.70
Family	$19.72

Refer to the carrier summary for specific details.

TERM LIFE AND AD&D (ACCIDENTAL DEATH & DISMEMBERMENT)

- Employer contributes 100% of the premium
- $40,000 life and accidental death dismemberment benefit
- Age reduction schedule applies, see Carrier booklet
- Refer to the carrier summary for specific details

VOLUNTARY TERM LIFE AND AD&D

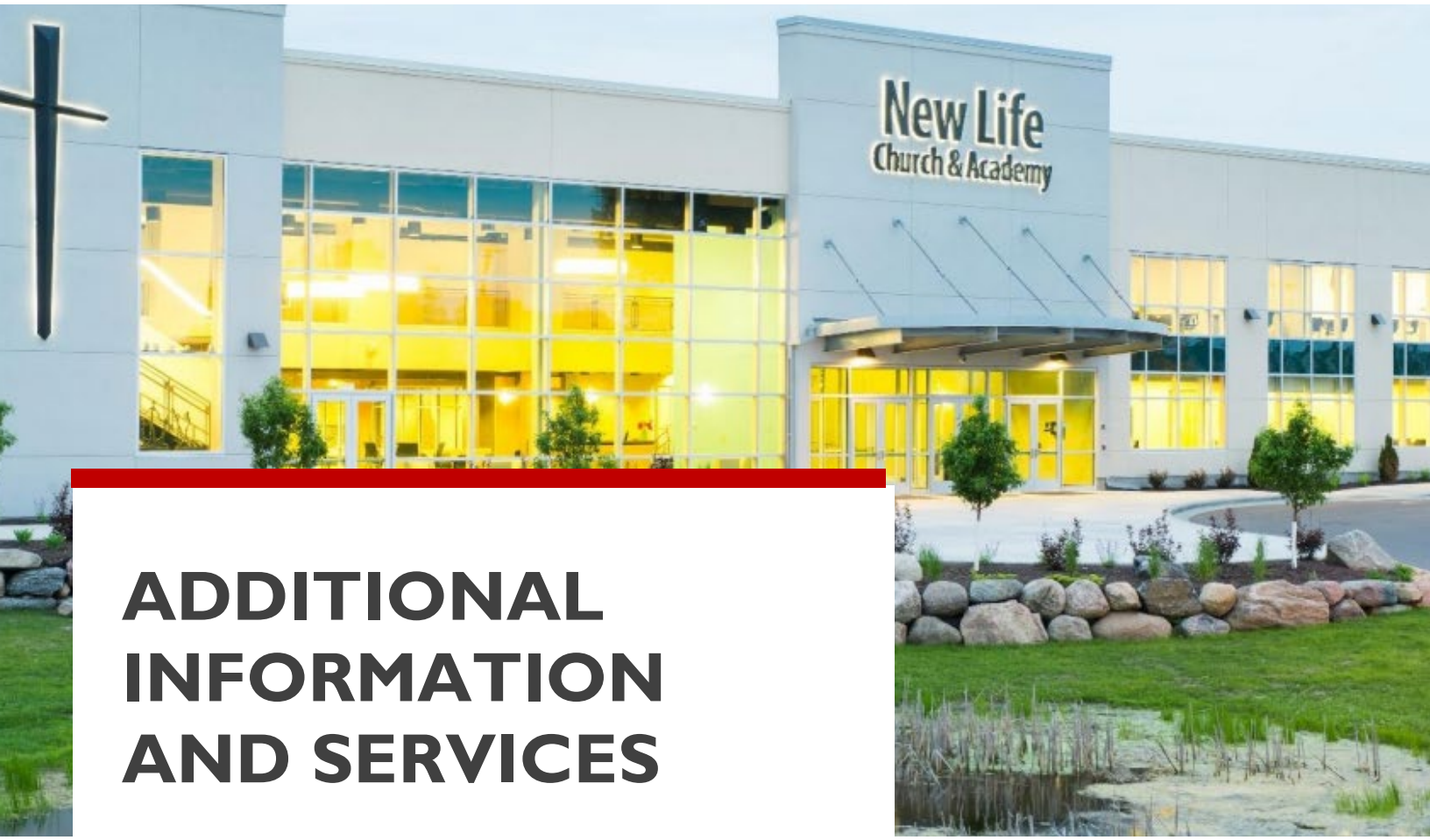
- Coverage is Voluntary and 100% paid by employee
- Guarantee Issue (available upon initial enrollment only):
  - Employee: $100,000
  - Spouse: $30,000
  - Dependent Children: $10,000
- Evidence of insurability is required if exceeding the guaranteed issue amount for underwriting approval
- Benefit can be purchased in increments:
  - Employee: $10,000 increments, not to exceed 5 times your annual earnings or $500,000 maximum
  - Spouse: $5,000 increments, up to $150,000 (cannot exceed 100% of employee's benefit)
  - Dependent Children (after 6 months of age): $10,000, Dependent children under 14 days old receive a $1,000 benefit
- Age reduction schedule applies, see Carrier booklet
- Refer to the carrier summary for specific details

DISABILITY

Employer contributes 50% to the employee's monthly premiums

	Long Term Disability
Elimination period	30 days of disability
Percentage of Income Replaced	60% of monthly income
Maximum Benefits Payable	$6,000 per month
Maternity Maximum Duration	N/A
Maximum Benefit Duration	Own occupation: 2 years Any occupation: to Social Security Retirement Age
Pre-existing Conditions	If an insured becomes disabled in the first twelve months of coverage, the claims team will do a pre-existing diagnosis investigation three months prior to the individual's effective date.
Benefit Taxability	Benefit is not taxable

Refer to the carrier summary for specific details.



ADDITIONAL INFORMATION AND SERVICES

25069 Aware® HSA $4,500 Deductible 0% Coinsurance

Benefit Summary | January 1, 2025 – December 31, 2025

Key benefits	In network MN Network: Aware® National Network: BlueCard® PPO	Out of network
What you will pay	You will pay the least when seeing an in-network provider.	You will pay the most when seeing an out-of-network or non-participating provider.
Your deductible The amount you pay per calendar year before your health plan starts to pay. Amounts paid out of network DO NOT apply to the in-network deductible.	Medical & Rx combined $4,500 $9,000	Medical & Rx combined $7,500 $15,000
Deductible type	Embedded - The plan begins paying benefits that require cost sharing for the first family member who meets the individual deductible. The family deductible must then be met by one or more of the remaining family members and then the plan pays benefits for all covered family members.	
Your coinsurance The percent of the allowed amount that you pay after your deductible is met.	0%	50%
Your out-of-pocket maximum The maximum amount you pay per calendar year in medical and prescription drug deductibles, coinsurance and copays. Amounts paid out of network DO NOT apply to the in-network out-of-pocket maximum.	Medical & Rx combined $4,500 $9,000	Medical & Rx combined $12,500 $25,000
Preventive care		
• well-child care to age 6	0%	0%
• prenatal care	0%	0%
• preventive medical evaluations age 6 and older; cancer screening; preventive hearing and vision exams; immunizations and vaccinations	0%	50% after the deductible
Physician services		
• e-visits	0% after the deductible	50% after the deductible
• retail health clinic (office visit)	0% after the deductible	50% after the deductible
• physician office visits	0% after the deductible	50% after the deductible
• office and outpatient lab services	0% after the deductible	50% after the deductible
• office and outpatient lab diagnostic imaging	0% after the deductible	50% after the deductible
• office and outpatient allergy injections and serum	0% after the deductible	50% after the deductible
• specialist office visits	0% after the deductible	50% after the deductible
• urgent care professional services	0% after the deductible	50% after the deductible
Other professional services		
• chiropractic manipulation (office visit)	0% after the deductible	50% after the deductible
• chiropractic therapy	0% after the deductible	50% after the deductible
• home health care	0% after the deductible	No Coverage
• physical therapy, occupational therapy, speech therapy (office visit)	0% after the deductible	50% after the deductible
• physical therapy, occupational therapy, speech therapy (therapy)	0% after the deductible	50% after the deductible
Inpatient facility services	0% after the deductible	50% after the deductible

Key benefits	In network MN Network: Aware® National Network: BlueCard® PPO	Out of network
Outpatient facility services		
• facility lab services	0% after the deductible	50% after the deductible
• facility diagnostic imaging	0% after the deductible	50% after the deductible
• surgery and anesthesia	0% after the deductible	50% after the deductible
• urgent care services (facility services)	0% after the deductible	50% after the deductible
Emergency care		
• emergency room (facility charges)	0% after the deductible	
• professional charges	0% after the deductible	
• ambulance (medically necessary transport to the nearest facility equipped to treat the condition)	0% after the deductible	
Durable Medical Equipment	0% after the deductible	50% after the deductible
Bariatric surgery	No Coverage	
Reproductive treatment	No Coverage	
Behavioral health (mental health and substance abuse services)		
• inpatient professional services	0% after the deductible	50% after the deductible
• outpatient professional services (office visits/office therapy)	0% after the deductible	50% after the deductible
• outpatient professional services (all other services)	0% after the deductible	50% after the deductible
• outpatient hospital/facility services	0% after the deductible	50% after the deductible
Prescription drugs – Classic Pharmacy Network **Retail** (31-day limit) **KeyRx drug list**		
• Tier 1 – Preferred generics	0% after the deductible	No Coverage
• Tier 2 – Non-preferred generics	0% after the deductible	No Coverage
• Tier 3 – Preferred brands	0% after the deductible	No Coverage
• Tier 4 – Non-preferred brands	0% after the deductible	No Coverage
Specialty drug list	0% after the deductible	No Coverage
90dayRx – Mail order pharmacy (90-day limit) or **Retail pharmacy** (90-day limit) **KeyRx drug list**		
• Tier 1 – Preferred generics	0% after the deductible	No Coverage
• Tier 2 – Non-preferred generics	0% after the deductible	No Coverage
• Tier 3 – Preferred brands	0% after the deductible	No Coverage
• Tier 4 – Non-preferred brands	0% after the deductible	No Coverage
Important information about your pharmacy benefits	The patient will pay the difference if a brand-name drug is dispensed when a generic drug is available. The drug list uses a step therapy program. More information about prescription drug coverage is available at **bluecrossmn.com.**	

This is only a summary of covered benefits. For detailed information about what is and isn't covered refer to plan benefit booklet or visit **bluecrossmn.com.** Members can also call Blue Cross customer service at the number on the back of their member ID card.

Each healthcare provider is an independent contractor and not our agent. It is up to the member to confirm provider participation in their network prior to receiving services.

25073 High Value HSA $4,500 Deductible 0% Coinsurance

Benefit Summary | January 1, 2025 – December 31, 2025

Key benefits	In network MN Network: High Value National Network: BlueCard® PPO	Out of network
What you will pay	You will pay the least when seeing an in-network provider.	You will pay the most when seeing an out-of-network or non-participating provider.
Your deductible The amount you pay per calendar year before your health plan starts to pay. Amounts paid out of network DO NOT apply to the in-network deductible.	Medical & Rx combined $4,500 $9,000	Medical & Rx combined $7,500 $15,000
Deductible type	Embedded - The plan begins paying benefits that require cost sharing for the first family member who meets the individual deductible. The family deductible must then be met by one or more of the remaining family members and then the plan pays benefits for all covered family members.	
Your coinsurance The percent of the allowed amount that you pay after your deductible is met.	0%	50%
Your out-of-pocket maximum The maximum amount you pay per calendar year in medical and prescription drug deductibles, coinsurance and copays. Amounts paid out of network DO NOT apply to the in-network out-of-pocket maximum.	Medical & Rx combined $4,500 $9,000	Medical & Rx combined $12,500 $25,000
Preventive care		
• well-child care to age 6	0%	0%
• prenatal care	0%	0%
• preventive medical evaluations age 6 and older; cancer screening; preventive hearing and vision exams; immunizations and vaccinations	0%	50% after the deductible
Physician services		
• e-visits	0% after the deductible	50% after the deductible
• retail health clinic (office visit)	0% after the deductible	50% after the deductible
• physician office visits	0% after the deductible	50% after the deductible
• office and outpatient lab services	0% after the deductible	50% after the deductible
• office and outpatient lab diagnostic imaging	0% after the deductible	50% after the deductible
• office and outpatient allergy injections and serum	0% after the deductible	50% after the deductible
• specialist office visits	0% after the deductible	50% after the deductible
• urgent care professional services	0% after the deductible	50% after the deductible
Other professional services		
• chiropractic manipulation (office visit)	0% after the deductible	50% after the deductible
• chiropractic therapy	0% after the deductible	50% after the deductible
• home health care	0% after the deductible	No Coverage
• physical therapy, occupational therapy, speech therapy (office visit)	0% after the deductible	50% after the deductible
• physical therapy, occupational therapy, speech therapy (therapy)	0% after the deductible	50% after the deductible
Inpatient facility services	0% after the deductible	50% after the deductible

Key benefits	In network MN Network: High Value National Network: BlueCard® PPO	Out of network
Outpatient facility services		
• facility lab services	0% after the deductible	50% after the deductible
• facility diagnostic imaging	0% after the deductible	50% after the deductible
• surgery and anesthesia	0% after the deductible	50% after the deductible
• urgent care services (facility services)	0% after the deductible	50% after the deductible
Emergency care		
• emergency room (facility charges)	0% after the deductible	
• professional charges	0% after the deductible	
• ambulance (medically necessary transport to the nearest facility equipped to treat the condition)	0% after the deductible	
Durable Medical Equipment	0% after the deductible	50% after the deductible
Bariatric surgery	No Coverage	
Reproductive treatment	No Coverage	
Behavioral health (mental health and substance abuse services)		
• inpatient professional services	0% after the deductible	50% after the deductible
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• outpatient professional services (all other services)	0% after the deductible	50% after the deductible
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Prescription drugs – Classic Pharmacy Network **Retail** (31-day limit) **KeyRx drug list**		
• Tier 1 – Preferred generics	0% after the deductible	No Coverage
• Tier 2 – Non-preferred generics	0% after the deductible	No Coverage
• Tier 3 – Preferred brands	0% after the deductible	No Coverage
• Tier 4 – Non-preferred brands	0% after the deductible	No Coverage
Specialty drug list	0% after the deductible	No Coverage
90dayRx – Mail order pharmacy (90-day limit) or **Retail pharmacy** (90-day limit) **KeyRx drug list**		
• Tier 1 – Preferred generics	0% after the deductible	No Coverage
• Tier 2 – Non-preferred generics	0% after the deductible	No Coverage
• Tier 3 – Preferred brands	0% after the deductible	No Coverage
• Tier 4 – Non-preferred brands	0% after the deductible	No Coverage
Important information about your pharmacy benefits	The patient will pay the difference if a brand-name drug is dispensed when a generic drug is available. The drug list uses a step therapy program. More information about prescription drug coverage is available at **bluecrossmn.com.**	

This is only a summary of covered benefits. For detailed information about what is and isn't covered refer to plan benefit booklet or visit **bluecrossmn.com.** Members can also call Blue Cross customer service at the number on the back of their member ID card.

Each healthcare provider is an independent contractor and not our agent. It is up to the member to confirm provider participation in their network prior to receiving services.

BlueCross BlueShield Minnesota

2025

AWARE® NETWORK

Open access to quality care

Your best choice for easy access to the largest selection of healthcare providers across Minnesota.

With 98 percent of doctors and 100 percent of hospitals in Minnesota, this broad, open-access network makes it easy to get the care you need. Small group plans are paired with BlueAccess℠ products.

TRAVEL WITH CONFIDENCE

When you travel outside the state, you have access to 1.7 million providers spanning every U.S. ZIP code through the national BlueCard® PPO network.* In addition, Blue Cross Blue Shield Global® Core gives you access to care in 190 countries and territories worldwide.

*The Aware Network includes providers one county into the neighboring states of Iowa, South Dakota, North Dakota and Wisconsin. When seeking care in these counties, search for providers using Aware Network (not BlueCard PPO).

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A NETWORK THAT FITS YOU

AWARE NETWORK

174 HOSPITALS

21,692 PRIMARY CARE PROVIDERS

51,400 SPECIALTY CARE PROVIDERS

Numbers are subject to change and are reflective of signed contracts as of January, 2024.

Network matters

Be sure to stay in the network. Your out-of-pocket costs will be higher when you see an out-of-network provider.

- Log in at **bluecrossmn.com/BCA** to find providers in your specific network
- Not a member? Visit **bluecrossmn.com/FindADoctor** and select the network you are considering

QUESTIONS?

Visit **bluecrossmn.com/BCA** or call the number on the back of your member ID card

Key in-network providers and hospitals

Choose from a broad selection of providers throughout Minnesota. **It's important to make sure your doctor or hospital is in the network before you receive care.**

Key providers

Allina Clinics
Alomere Health
Avera Clinics
Center for Diagnostic Imaging
Children's Clinics
Entira Clinics
Essentia Health Clinics
HealthPartners Clinics
M Health Fairview Clinics
Mayo Clinics
Minnesota Gastroenterology
Minnesota Oncology Hematology, PA Associates
North Clinic
North Memorial Health Clinics
Park Nicollet Clinics
Sanford Health Clinics
St. Luke's Clinics
St. Paul Radiology/Midwest Radiology
Summit Orthopedics
Twin Cities Orthopedics
University of Minnesota Physicians
Winona Health

Key hospitals

Abbott Northwestern Hospital
Avera Hospitals
CentraCare Health (includes Carris Health)
Children's Hospitals
Essentia Health Hospitals
Hennepin County Medical Center
Lakeview Hospital
Maple Grove Hospital
Mayo Clinic Hospitals
Mercy Hospital
Park Nicollet Methodist Hospital
North Memorial Health Hospitals
Regions Hospital
Sanford Hospitals
St. Cloud Hospital
St. Francis Regional Medical Center
St. John's Hospital
St. Joseph's Hospital
St. Luke's Hospitals
United Hospital
University of Minnesota Medical Center
Woodwinds Hospital

Provider listings are not all-inclusive and are subject to change.

M01458R08 (9/24)

BlueCross BlueShield Minnesota

2025

HIGH VALUE NETWORK

Statewide access to quality care

Your best choice for quality care at an affordable price with a broad selection of healthcare providers. The High Value Network includes leading doctors, clinics and hospitals across Minnesota.

TRAVEL WITH CONFIDENCE

When you travel outside the state, you have access to 1.7 million providers spanning every U.S. ZIP code through the national BlueCard® PPO network.* In addition, Blue Cross Blue Shield Global® Core gives you access to care in 190 countries and territories worldwide.

*The High Value Network includes providers one county into the neighboring states of Iowa, South Dakota, North Dakota and Wisconsin. When seeking care in these counties, search for providers using High Value Network (not BlueCard PPO).

To enroll in this plan, the employer must be based in Minnesota and the employee must live in the High Value Network service area.

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A NETWORK THAT FITS YOU

HIGH VALUE NETWORK

122 HOSPITALS

14,633 PRIMARY CARE PROVIDERS

40,410 SPECIALTY CARE PROVIDERS

Numbers are subject to change and are reflective of signed contracts as of January 2024.

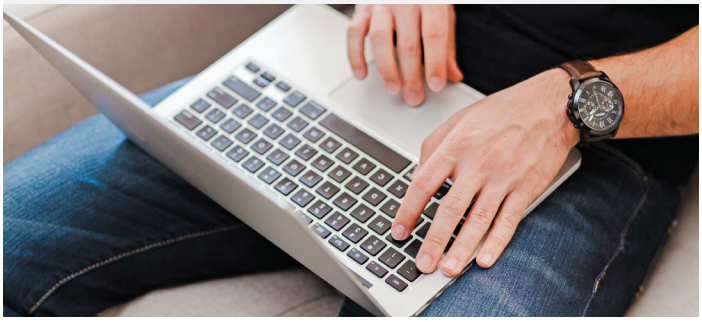
Network matters

Be sure to stay in the network. Your out-of-pocket costs will be higher when you see an out-of-network provider.

- Log in at **bluecrossmn.com/BCA** to find providers in your specific network
- Not a member? Visit **bluecrossmn.com/FindADoctor** and select the network you are considering

QUESTIONS?

Visit **bluecrossmn.com/BCA** or call the number on the back of your member ID card



Providers you know and trust

Choose from a broad selection of providers throughout Minnesota. **It's important to make sure your doctor or hospital is in the network before you receive care.**

Metro

Allina Health
CentraCare Health
Children's Hospitals and Clinics
Entira
Hennepin County Medical Center
M Health Fairview
Mankato Clinic Ltd
North Memorial Health
Northfield Hospital and Clinic
Ridgeview
St. Croix Regional Medical Center
University of Minnesota Physicians

Central

CentraCare Health (includes Carris Health)
Cuyuna Regional Medical Center
Integrity Health Network
M Health Fairview

Northeast

Grand Itasca Clinic & Hospital
Integrity Health Network
M Health Fairview
St. Luke's
Welia Health

Northwest/Southwest

Alomere Health
Altru Health System
CentraCare Benson (includes Carris Health)
Integrity Health Network
Lake Region Healthcare
Lakewood Health System
Sanford Health

Southeast

Allina Health
Children's Hospitals & Clinics
Gundersen Health System
Mankato Clinic
Northfield Hospital & Clinics
Olmsted Medical Center
Winona Health

Provider listings are not all-inclusive and are subject to change.

M01260R09 (8/24)

nice

Healthcare That's Nice

Our mission is simple

make getting amazing everyday care easy and affordable

> "They were so personable and made me feel as comfortable as possible, and really made time to learn about me and my health issues. I highly recommend Nice.
>
> **Angela K.**
> Nice Healthcare Patient

The Nicest Benefit

These are the **free** integrated primary care services that Nice Healthcare® offers with no out-of-pocket fees:

- Virtual Chat and Video Visits
- In-Home Visits with 35 Free Labs and Physical Tests
- 550+ Free Medications Can Be Prescribed by Our Clinicians
- Virtual Physical Therapy Visits
- Virtual Mental Health Therapy Visits
- In-Home X-rays and EKG Services

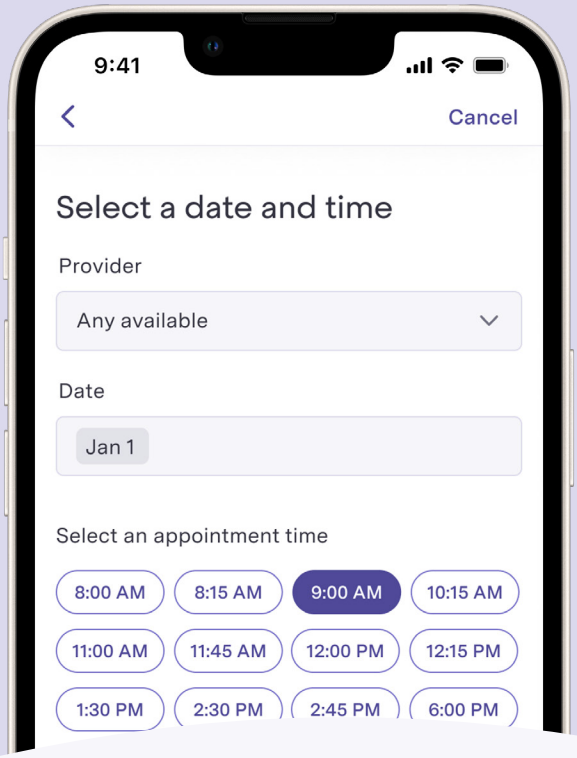
Visit **nice.healthcare**

*You may incur a small visit fee if you are enrolled in a High Deductible Health Plan (HDHP). Please confirm with your employer for further details.

It All Starts With The Nice App

Whenever you and your dependents need Nice, you'll begin the process by scheduling a virtual visit with a clinician. All virtual services are conducted using the Nice app, including chat and video visits, physical therapy and mental health therapy.

In addition to scheduling and conducting visits, you will also use the Nice app to review treatment plans, upload documents and manage your accounts.



The Clinic That Comes To You

We offer our clinician services in parts of Arizona, Colorado, Idaho, Iowa, Minnesota, Nebraska, Nevada, New Mexico, Oregon, Utah, Washington, and Wisconsin.

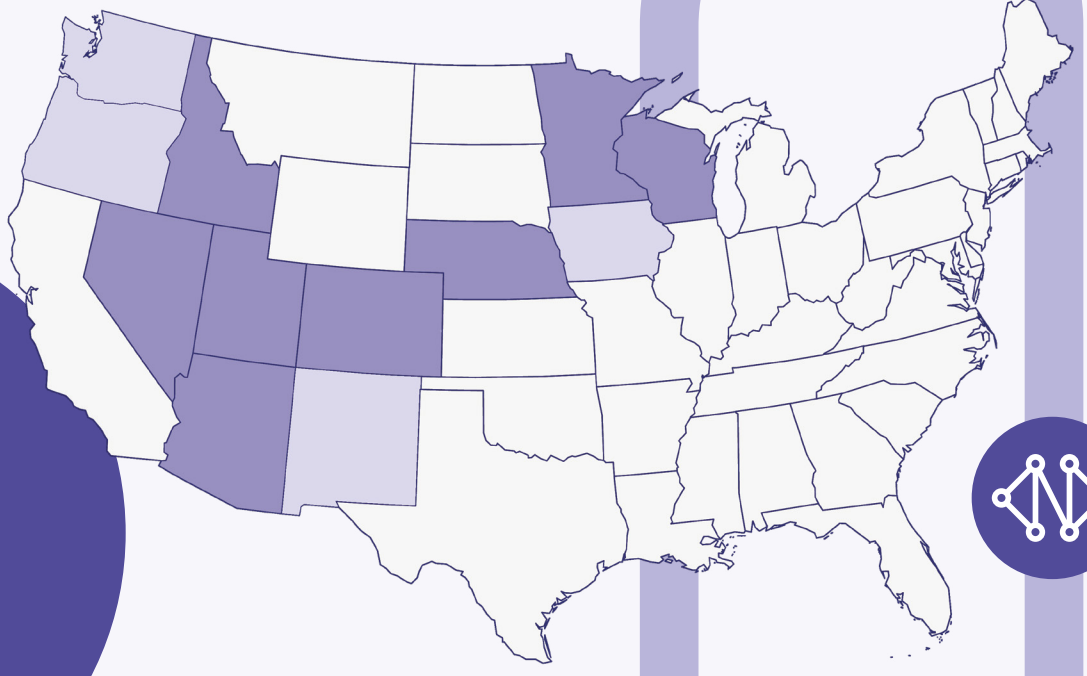
- Virtual Only
- Virtual & In-Home

Online Visit Hours

mon - fri	8am - 7pm CT
sat - sun	9am - 12pm CT
mon - fri	7am - 6pm MT
sat - sun	8am - 11am MT
mon - fri	6am - 5pm PT
sat - sun	7am - 10am PT

Home Visit Hours (local time)

mon - fri 9am - 5pm



Download the app

SPECIAL NOTICES

PLAN YEAR: 2025

KRAUS-ANDERSON® *Insurance*

CONTACT INFORMATION

PLAN ADMINISTRATOR	
Contact Name:	Katie Mellett
Phone Number:	651-757-4166
E-mail:	katiemellett@newlifeacademy.org
HEALTH INSURANCE PROVIDER	
Health Insurer:	BlueCross BlueShield MN
Customer Service:	651-662-8000
Website:	www.bluecrossmn.com
PRIVACY OFFICER	
Contact Name:	Katie Mellett
Business Address:	6758 Bailey Road
	Woodbury, MN 55129
Phone Number:	651-757-4166
E-mail:	katiemellett@newlifeacademy.org
Website:	www.newlifeacademy.org
MEDICARE PART D	
Creditable:	$4,500-0% HSA Aware & High Value Plans

The information in this Special Notices is presented is based on information required by law. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Special Notices and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact your plan administrator.

WHCRA ENROLLMENT NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manager 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 complication of mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: see your Certificate of Coverage or Summary Plan Description. If you would like more information on WHCRA benefits, call Customer Service at the number on the back of your ID card.

SPECIAL ENROLLMENT NOTICE

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

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

To request special enrollment or obtain more information contact your plan administrator.

NEWBORN'S ACT DISCLOSURE

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, required that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

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

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

How Can I Get More Information?

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

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.

YOUR INFORMATION, YOUR RIGHTS, OUR RESPONSIBILITIES

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

Your Rights

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

Get a copy of your health and claims record	• You can ask to see or get a copy of your health and claims records and otherhealth information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are correct or incomplete. Ask us how to do this. • We may say “no” to your request, but we’ll tell you why in writing within 60 days.
Request confidential communication	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests and must say “yes” if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say “no” if it would affect your care.
Get a list of these with whom we’ve shared information	• You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive this notice electronically. We will provide you with a paper copypromptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the Privacy Officer contact information. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices

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

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or other involved in payment for your care • Share information in a disaster relief situations • Contact you for fundraising efforts • If you are not able to tell us your preference, for example if you are unconscious we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases we never share your information unless you give us written permission:	• Marketing purposes • Sale of your information

Our Uses and Disclosures

How do we typically us or share your health information? We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.
Run our organization	• We can use and disclose your information to run our organization and contract you when necessary. • We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.	Example: We use health information about you to develop better services for you.
Pay for your health services	• We can use and disclose your health information as we pay for yourhealth services	Example: We share information about you with your dental plan to coordinate payment for your dental work.
Administer your plan	• We may disclose your health informationto your health plan sponsor for plan administration.	Example: Your company contacts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

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

Help with public health and safety issues	• We can share health information about you for certain situations suchas: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health orsafety
Do research	• We can use or share your information for health research
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurementorganizations. • We can share health information with a coroner, medical examiner, orfuneral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

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

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

Changes to the Terms of this Notice

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

GINA DISCLOSURE

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

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.

MENTAL HEALTH & ADDICTION EQUITY ACT DISCLOSURE

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the company's group health plan with respect to mental health or substance use disorder benefits, pleasecontact the plan administrator.

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 the qualifying event occurs. You must provide this notice to the Plan Administrator.

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. Contact the COBRA Administrator immediately or as soon as possible to notify them of this qualification.

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.

ADA WELLNESS PROGRAM NOTICE

Our wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the incentive.

Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the plan administrator.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health potential risks and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and our company may use aggregate information it collects to design a program based on identified health risks in the workplace, we will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is your doctor in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the plan administrator.

Wellness Program Disclosure

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact your plan administrator and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

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
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
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	**UTAH – Medicaid and CHIP**

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

To see if any other states have added a premium assistance program since 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.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

[*Insert plain languagesummary of any applicable state balance billing laws or requirements OR state-developed language as appropriate*]

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia,

pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

[*Insert plain languagesummary of any applicable state balance billing laws or requirements OR state-developed language regarding applicable state law requirements as appropriate*]

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact:

- The US Department of Health and Human Services at:

  Phone: 800-985-3059

  Website: https://www.cms.gov/nosurprises/consumers

- Your state agency, which can be found at:

  https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE CREDITABLE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage 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. We have determined that the prescription drug coverage offered by the company 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 drugplan.

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 coverage will not be affected. Please see the Insurance Carrier for additional information regarding plan coverage

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

When will you pay a higher premium (penalty) to join a Medicare drug plan?

- You should also know that if you drop or lose your current coverage 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 as the plan administrator 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 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).

GLOSSARY

Glossary is for benefit general terms and may not all apply to your plan(s).

Allowed Amount - The highest amount that will cover (pay) a service.

Benefit Period - When services are covered under your plan. It also defines the time when benefit maximums, deductibles and coinsurance limits build up. It has a start and end date. It is often one calendar year for health insurance plans. *Example: You may have a plan with a benefit period of January 1 through December 31 that covers 10 physical therapy visits. The 11th or more sessions will not be covered.*

Brand - A prescription drug product which is manufactured and marketed under a trademark or name by a specific drug manufacturer, or that is identified as a brand name product.

Coinsurance - A certain percentage you must pay each benefit period after you have paid your deductible. This payment is for covered services only. You may still have to pay a copay. *Example: Your plan might cover 80 percent of your medical bill. You will have to pay the other 20 percent. The 20 percent is the coinsurance.*

Coinsurance Limit (or Maximum) - The most you will pay in coinsurance costs during a benefit period.

Condition - An injury, ailment, disease, illness, or disorder.

Contract - The agreement between an insurance company and the policyholder.

Coordination of Benefits (COB) – A process to determine who pays first when two or more health insurance plans are responsible for paying the same medical claim. You may be required to complete a form from the insurer(s) to help with this determination. Claims are typically held until COB is established.

Copayment (Copay) - The amount you pay to a healthcare provider at the time you receive services. You may have to pay a copay for each covered visit to your doctor, depending on your plan. Not all plans have a copay.

Covered Charges - Charges for covered services that your health plan paid for. There may be a limit on covered charges if you receive services from providers outside your plan's network of providers.

Covered Person - Any person covered under the plan.

Covered Service - A healthcare provider's service or medical supplies covered by your health plan. Benefits will be given for these services based on your plan.

Creditable Coverage - Coverage of a person under any of these:
A group health plan. This includes church and governmental plans.
Health insurance coverage.
Medicare (Part A or Part B of Title XVIII of the Social Security Act).
Medicaid (Title XIX of the Social Security Act, other than coverage consisting only of benefits under Section 1928).
The health plan for active military personnel. This includes TRICARE.
The Indian Health Service or other tribal organization program.
A state health benefits risk pool.
The Federal Employees Health Benefits Program.
A public health plan (as defined in federal regulations).
A health benefit plan under section 5 (c) of the Peace Corps Act.
Any other plan which gives complete hospital, medical and surgical services.

Deductible - The amount you pay for your healthcare services before your health insurer pays. Deductibles are based on your benefit period (typically a year at a time). *Example: If your plan has a $2,000 annual deductible, you will be expected to pay the first $2,000 toward your healthcare services.*

Dependent Coverage - Coverage for your dependents who qualify.

Emergency Medical Condition - A medical problem with sudden and severe symptoms that must be treated quickly. In an emergency, a person with no medical training and an average knowledge of health/medicine could reasonably expect the problem could:
Put a person's health at serious risk.
Put an unborn child's health at serious risk.
Result in serious damage to the person's body and how his or her body works.
Result in serious damage to a person's organ or any part of the person.

Experimental or Investigational Drug, Device, Medical Treatment or Procedure - These are not approved by the U.S. Food and Drug Administration (FDA) or are not considered the standard of care

Explanation of benefits - the health insurance company's written explanation of how a medical claim was paid. It contains detailed information about what the company paid and what portion of the costs you are responsible for.

Generic - A prescription drug product that is chemically equivalent to a brand-name drug; or that the claims administrator identifies as a generic product based on available data resources.

Health Assessment - A health survey that measures your current health, health risks and quality of life.

Inpatient Services - Services received when admitted to a hospital and a room and board charge is made.

Institution (Institutional) - A hospital or certain other facility.

Legal Guardian - The person who takes care of a child and makes healthcare decisions for the child. This person is the natural parent or was made caretaker by a court of law.

Medical Care - Medical services received from a healthcare provider or facility to treat a condition.

Medically Necessary (or Medical Necessity) - Services, supplies or prescription drugs that are needed to diagnose or treat a medical condition. Also, an insurer must decide if this care is:
Accepted as standard practice. It can't be experimental or investigational.
Not just for your convenience or the convenience of a provider.
The right amount or level of service that can be given to you.
Example: Inpatient care is medically necessary if your condition can't be treated properly as an outpatient service.

Medicare - A federal program for people aged 65 or older that pays for certain healthcare expenses.

Network Provider/In-network Provider - A healthcare provider who is part of a plan’s network.

Non-covered Charges - Charges for services and supplies that are **not** covered under the health plan. Examples of non-covered charges may include things like acupuncture, weight loss surgery or marriage counseling. Consult your plan for more information.

Non-network Provider/Out-of-network Provider - A healthcare provider who is **not** part of a plan’s network. Costs associated with out-of-network providers may be higher or not covered by your plan. Consult your plan for more information.

Outpatient Services - Services that do not need an overnight stay in a hospital. These services are often provided in a doctor's office, hospital, or clinic.

Out-of-pocket Cost - Cost you must pay. Out-of-pocket costs vary by plan and each plan has a maximum out-of-pocket (MOOP) cost. Consult your plan for more information.

Per Member Per Month (PMPM) - The average cost or quantity per month based on active membership.

Pre-existing condition - a health problem that has been diagnosed, or for which you have been treated, before buying a health insurance plan.

Preventive Care - Regular care that is generally performed by a primary care physician (e.g., physicals, health screenings).

Primary Care Provider - A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates, or helps a patient access a range of health care services.

Provider (Healthcare Provider) - A hospital, facility, physician, or other licensed healthcare professional.

Urgent Care Provider - A provider of services for health problems that need medical help right away but are not emergency medical conditions.

Specialist - A physician that specializes in a specific area of medicine.

Waiting period - the period of time that an employer makes a new employee wait before he or she becomes eligible for coverage under the company's health plan. Also, the period of time beginning with a policy's effective date during which a health plan may not pay benefits for certain pre-existing conditions.