

2022-2023

Benefit Summary



Table of Contents

| | |
|---|----|
| Introduction/Highlights..... | 3 |
| Benefits Overview..... | 4 |
| Contact Information..... | 5 |
| Benefits at a Glance..... | 6 |
| Medical Insurance..... | 7 |
| UHC Value Adds..... | 10 |
| Health Savings Account..... | 16 |
| Flexible Spending Account..... | 17 |
| MAWSECO Approved 403(b)/457(b) Vendors..... | 18 |
| Salary Reduction Agreement Form..... | 19 |
| Dental Insurance..... | 21 |
| Vision Insurance..... | 22 |
| Life and AD&D Insurance..... | 25 |
| Long-term Disability Insurance..... | 28 |
| Employee Assistance Program..... | 30 |
| Virtual Fitness..... | 32 |
| Horace Mann Student Loan Solutions..... | 34 |
| Enrollment Forms..... | 35 |
| Annual Notices..... | 45 |

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.

Introduction / Highlights

Meeker and Wright Special Education Cooperative is pleased to provide competitive benefits that you can tailor to meet your needs and the needs of your family. This benefits guide outlines your 2022 employee benefits through **Meeker and Wright Special Education Cooperative**.

Annual Open Enrollment

Meeker and Wright Special Education Cooperative offers two open enrollment periods. Medical, Vision and FSA will be open in the end of August and run through early September. Dental's open enrollment period will open in the end of May and run through early June. These periods give you the chance to change your current benefit elections. During open enrollment, you can review your current elections and make changes for the upcoming year. The benefit choices you make during the annual open enrollment period will remain in effect for the entire upcoming year.

Qualifying Life Event

You cannot change your benefit coverage during the plan year unless you experience or have a qualifying life event. The Internal Revenue Service (IRS) defines a qualifying life event as a change in:

- Marital Status: Marriage, divorce, legal separation, or annulment.
- Number of dependents: Birth, adoption, or change in work schedule by you, your spouse, or your dependent if it affects eligibility.
- Dependent Status: Gain or loss of eligibility because of age.
- Spouse's Annual Enrollment: Spouse makes changes that impact your benefit elections.
- Qualified Medical Child Support Order (QMCSO)

If you have questions relating to a qualifying life event, contact **Elizabeth Sullivan at 612.417.6491**



Benefits Overview

Meeker and Wright Special Education Cooperative is proud to offer a comprehensive benefits package to eligible employees who work 30 hours per week. The complete benefits package is briefly summarized in this booklet. You will receive plan booklets, which give you more detailed information about each of these programs.

You share the costs of some benefits (medical, and dental) and **Meeker and Wright Special Education Cooperative** provides other benefits at no cost to you (life, accidental death & dismemberment, and Long-term Disability). In addition, there are voluntary benefits with reasonable group rates that you can purchase through payroll deductions.

Benefits Offered

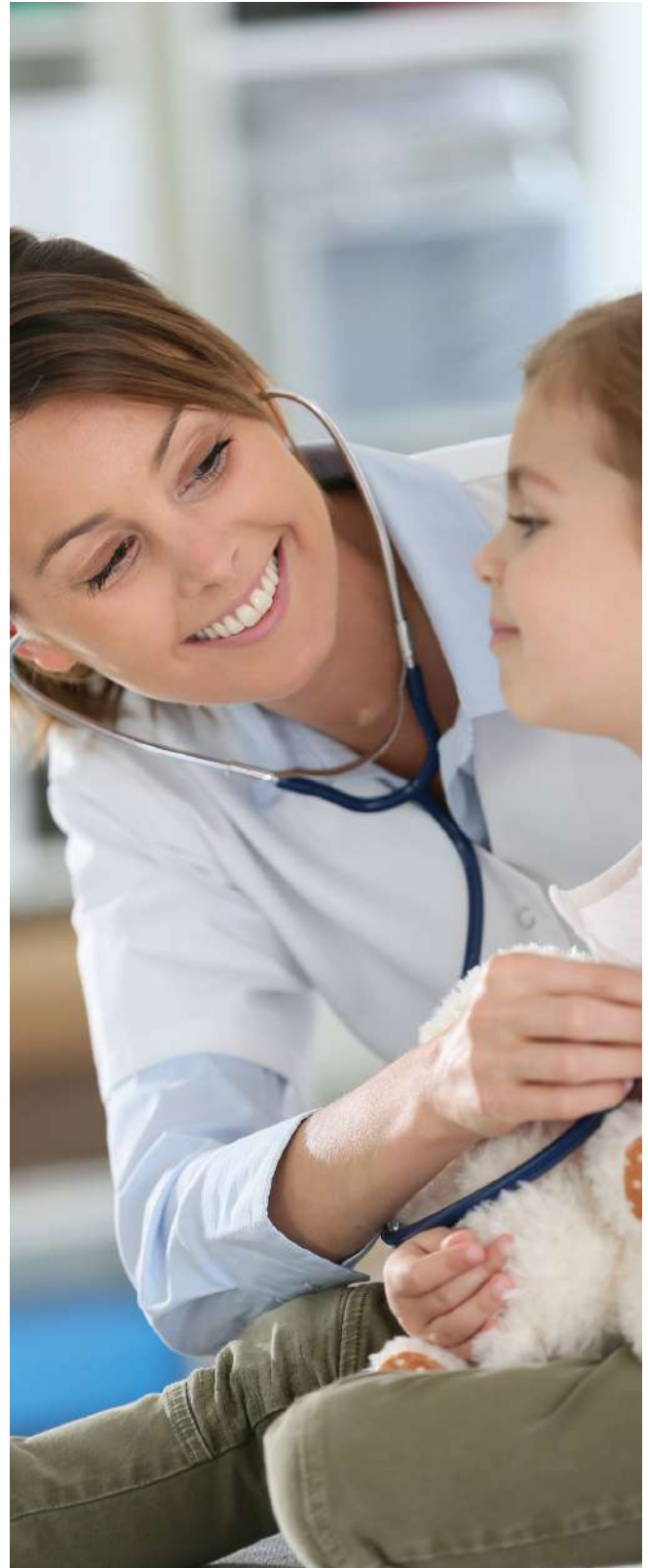
- Medical
- Dental
- Vision
- Life Insurance
- Accidental Death & Dismemberment (AD&D) Insurance
- Long-Term Disability
- Employee Assistance Program

Eligibility

You and your dependents are eligible for **Meeker and Wright Special Education Cooperative** benefits on the first of the month following your Date of Hire.

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

Elections made now will remain until the next open enrollment period unless you or your family members experience a qualifying event. If you experience a qualifying event, you must contact HR within 30 days to make the necessary changes.



Contact Information

Below is a listing of **Meeker and Wright Special Education Cooperative** benefits partners for the plans described in this guide. This list should be your first point of contact in resolving any issues relating to the various benefit plans.

| Benefit | Administrator | Phone | Website/Email |
|---------------------------|--------------------|--------------|--|
| Medical | United HealthCare | 866.414.1959 | www.myuhc.com |
| Dental | HealthPartners | 800.883.2177 | www.healthpartners.com |
| Life and Disability | NIS | 800.392.7295 | www.nisbenefits.com |
| Employer Paid Vision | United HealthCare | 800.638.3120 | www.myuhcvision.com |
| Voluntary Vision | VSP | 800.877.7195 | www.vsp.com |
| Health Savings Account | Wex | 800.761.7181 | ww.wexinc.com |
| Flexible Spending Account | Wex | 800.761.7181 | www.wexinc.com |
| MAWSECO Representative | Justin Kroeger | 952.918.3944 | Justin_Kroeger@ajg.com |
| MAWSECO | Elizabeth Sullivan | 612.417.6491 | esullivan@mawseco.k12.mn.us |



Benefits at a Glance

| Plan | Description |
|---------------------------------------|--|
| Medical Plan | Meeker and Wright Special Education Cooperative offers three plans through United HealthCare: the \$1,000-80% Plan, the \$3,500-100% HSA Plan and the \$6,750-100% HSA Plan. This plan menu gives employees options to best fit their needs. Meeker and Wright Special Education Cooperative pays a portion of the plan cost in accordance with contract provisions. |
| Dental Plan | Meeker and Wright Special Education Cooperative offers a comprehensive dental plan through HealthPartners. Meeker and Wright Special Education Cooperative pays a portion of the plan cost in accordance with contract provisions. |
| Vision coverage under UHC | Meeker and Wright Special Education Cooperative offers a vision plan through UHC covering spectacle lenses, frames, and contact lenses. This plan is in conjunction with the health insurance and is paid for in accordance with health insurance contributions specified in the employee contract. |
| Voluntary Vision | Meeker and Wright Special Education Cooperative offers a vision plan through VSP covering spectacle lenses, frames, and contact lenses. This plan is 100% paid for by the <u>employee</u> . |
| Basic Life Insurance | Meeker and Wright Special Education Cooperative provides employees basic life insurance through National Insurance Services. (NIS) |
| Long-term Disability Insurance | Meeker and Wright Special Education Cooperative provides employees Long-term Disability Insurance through National Insurance Services. (NIS) |
| Health Savings Account (HSA) | Employees who enroll in the HDHP (HSA plans) for the year 2022 may contribute a maximum of \$3,650 for those enrolling in single coverage and \$7,300 for those enrolling in family coverage. For those individuals who are 55 and older, you can add an additional \$1,000 as an HSA catch-up contribution. |
| Flexible Spending Accounts | <p>Health Care FSA – Employees who are enrolled in the \$1,000 medical plan can elect the FSA for unreimbursed medical, dental and vision expenses and may contribute up to \$2,850 per year on a pre-tax basis.</p> <p>For employees in the HSA plans the FSA dollars are limited to Dental and Vision expenses.</p> <p>Dependent Care FSA – Employees may contribute up to \$5,000 per year on a pre-tax basis for eligible dependent care expenses.</p> |

Medical Benefits- \$1,000—80%

Administered by United HealthCare

| Plan 1 | \$1,000 Deductible, 20% Coinsurance, \$3,000 OOP |
|---|--|
| | In-Network |
| Lifetime Benefit Maximum | Unlimited |
| Annual Deductible | \$1,000 per individual / \$2,000 per family |
| Annual Out-of-Pocket Maximum (Includes deductible) | \$3,000 per individual / \$6,000 per family |
| Coinsurance | You pay 20% after deductible |
| Doctors Office | |
| Preventive Visits | Well-Child Care, Prenatal Care and In Network Preventive services: 100% No Deductible |
| Primary Care Office Visit | \$25 copay per visit, deductible does not apply |
| Specialist Office Visit | \$25/\$50 copay per visit, deductible does not apply |
| Urgent Care | \$25 copay per visit, deductible does not apply |
| Diagnostic Test (X-rays/tests, blood work) | No Charge |
| Imaging (CT/PET scans, MRI) | You pay 20% after deductible |
| Hospital Services | |
| Emergency Room | You pay 20% after deductible |
| Inpatient Services | You pay 20% after deductible |
| Outpatient Surgery | You pay 20% after deductible |
| Mental Health Services / Substance Abuse Services | |
| Inpatient Services | You pay 20% after deductible |
| Outpatient Services | \$25 copay per visit, deductible does not apply |
| Maternity Services | |
| Office Visits | 100% No Deductible |
| Childbirth/Delivery Professional/Facility services | You pay 20% after deductible |
| Prescription Drugs | |
| <u>Tier 1 Drugs</u> Up to a 31-day supply per prescription | \$20 copay, deductible does not apply |
| <u>Tier 2 Drugs</u> Up to a 31-day supply per prescription | \$50 copay, deductible does not apply |
| <u>Tier 3 Drugs</u> Up to a 31-day supply per prescription | \$100 copay, deductible does not apply |
| <u>Tier 4 Drugs</u> Up to a 31-day supply per prescription | Not Applicable |

Medical Benefits- \$3,500—100% HSA

Administered by United HealthCare

| Plan 2 | \$3,500 Deductible, 0% Coinsurance, \$3,500 OOP HSA |
|--|--|
| | In-Network |
| Lifetime Benefit Maximum | Unlimited |
| Annual Deductible | \$3,500 per individual / \$7,000 per family |
| Annual Out-of-Pocket Maximum (Includes deductible) | \$3,500 per individual / \$7,000 per family |
| Coinsurance | You pay 0% after deductible |
| Doctors Office | |
| Preventive Visits | Well-Child Care, Prenatal Care and In Network Preventive services: 100% No Deductible |
| Primary Care Office Visit | You pay 0% after deductible |
| Specialist Office Visit | You pay 0% after deductible |
| Urgent Care | You pay 0% after deductible |
| Diagnostic Test (X-rays/tests, blood work) | You pay 0% after deductible |
| Imaging (CT/PET scans, MRI) | You pay 0% after deductible |
| Hospital Services | |
| Emergency Room | You pay 0% after deductible |
| Inpatient Services | You pay 0% after deductible |
| Outpatient Surgery | You pay 0% after deductible |
| Mental Health Services / Substance Abuse Services | |
| Inpatient Services | You pay 0% after deductible |
| Outpatient Services | You pay 0% after deductible |
| Maternity Services | |
| Office Visits | 100% No Deductible |
| Childbirth/Delivery Professional/Facility services | You pay 0% after deductible |
| Prescription Drugs | |
| <u>Tier 1 Drugs</u> | |
| Up to a 31-day supply per prescription | \$0 copay |
| <u>Tier 2 Drugs</u> | |
| Up to a 31-day supply per prescription | \$0 copay |
| <u>Tier 3 Drugs</u> | |
| Up to a 31-day supply per prescription | \$0 copay |
| <u>Tier 4 Drugs</u> | |
| Up to a 31-day supply per prescription | Not Applicable |

Medical Benefits- \$6,750—100% HSA

Administered by United HealthCare

| Plan 3 | \$6,750 Deductible, 0% Coinsurance, \$6,750 OOP HSA |
|--|--|
| | In-Network |
| Lifetime Benefit Maximum | Unlimited |
| Annual Deductible | \$6,750 per individual / \$13,500 per family |
| Annual Out-of-Pocket Maximum (Includes deductible) | \$6,750 per individual / \$13,500 per family |
| Coinsurance | You pay 0% after deductible |
| Doctors Office | |
| Preventive Visits | Well-Child Care, Prenatal Care and In Network Preventive services: 100% No Deductible |
| Primary Care Office Visit | You pay 0% after deductible |
| Specialist Office Visit | You pay 0% after deductible |
| Urgent Care | You pay 0% after deductible |
| Diagnostic Test (X-rays/tests, blood work) | You pay 0% after deductible |
| Imaging (CT/PET scans, MRI) | You pay 0% after deductible |
| Hospital Services | |
| Emergency Room | You pay 0% after deductible |
| Inpatient Services | You pay 0% after deductible |
| Outpatient Surgery | You pay 0% after deductible |
| Mental Health Services / Substance Abuse Services | |
| Inpatient Services | You pay 0% after deductible |
| Outpatient Services | You pay 0% after deductible |
| Maternity Services | |
| Office Visits | 100% No Charge |
| Childbirth/Delivery Professional/Facility services | You pay 0% after deductible |
| Prescription Drugs | |
| <u>Tier 1 Drugs</u> | |
| Up to a 31-day supply per prescription | \$0 Copay |
| <u>Tier 2 Drugs</u> | |
| Up to a 31-day supply per prescription | \$0 Copay |
| <u>Tier 3 Drugs</u> | |
| Up to a 31-day supply per prescription | \$0 Copay |
| <u>Tier 4 Drugs</u> | |
| Up to a 31-day supply per prescription | Not Applicable |

Activate your myuhc.com account

Put your health plan at your fingertips

Get the most out of your benefits

Your personalized website, myuhc.com®, features tools designed to help you:

- **Find, price and save on care**—you can save with Virtual Visits® and other tools. You can save an average of 36%¹ when you compare costs for providers and services
- **Get care from anywhere** with Virtual Visits. A doctor can diagnose common conditions by phone or video 24/7
- **Understand your benefits** and the financial impact of care decisions
- **Find tailored recommendations** regarding providers, products and services. You can even generate an out-of-pocket estimate based on your specific health plan status
- **Access claim details**, plan balances and your health plan ID card quickly
- **Follow through on clinical recommendations** and access wellness programs
- **Order prescription refills**, get estimates and compare medication pricing**
- **Check your plan balances**, access financial accounts and more



Download the UnitedHealthcare® app

It's perfect for on-the-go access, help finding a nearby doctor and more.

**United
Healthcare**

Activation is quick

1

Go to myuhc.com > **Register Now**

2

Fill out the required fields and create your username/password

3

Enter your contact information and security questions

4

Agree to the website's policies and be sure to opt-in for email updates. We promise you'll only see our name in your inbox with relevant news and wellness updates



Health and wellness programs designed to help you live a healthier lifestyle.

As a UnitedHealthcare member, the following programs are available to you. For more information visit: myuhc.com or the UnitedHealthcare app



Medical

Your plan has access to a national network and the choice of out-of-network coverage. A network is a group of health care providers and facilities that have a contract with UnitedHealthcare. You can receive care and services from anyone in our network. Out-of-network means that a provider does not have a contract with UnitedHealthcare. It's important to remember, seeing an out-of-network provider may cost you more. There's no need to select a primary care physician (PCP) or get referrals to see a specialist. But, consider choosing a PCP. Your PCP can be your partner in managing your care. They can help you avoid duplicating tests and services and connect you to a specialist. Lastly, most UnitedHealthcare plans cover preventive services without additional cost sharing to you.¹

Visit the [UnitedHealthcare app](https://myuhc.com) or call the number on your health plan ID card to connect with a Client Advocate today.



myuhc.com and UnitedHealthcare app

myuhc.com[®] is your personalized website. It helps you access and manage your health plan and health information. Use it to find network doctors and facilities, check your coverage and claims status, review preventive care services, print a temporary ID card and check your plan balance. You can also download the UnitedHealthcare app^{*} from the App Store[®] or Google Play[™].



Pharmacy

OptumRx[®] is your UnitedHealthcare plan's pharmacy care services manager. OptumRx is committed to helping provide you with safer, easier and lower cost ways to get the medication you need. The UnitedHealthcare Prescription Drug List (PDL) is the list of medications that are covered by the plan.² The PDL is organized by cost levels, known as tiers. Choosing medications in the lower tiers may save you money. Ask your doctor or check your PDL for lower-cost options. If you have a medication that is placed in a higher tier (Tier 3, for example), check to see if a lower-tier option is available at myuhc.com.



Virtual Visits

Save time by seeing a doctor from your mobile device or computer 24/7. With a Virtual Visit, you can talk — by phone or video—to a doctor who can diagnose common medical conditions and even prescribe medications, if needed.* Go to myuhc.com/virtualvisits to get started.



Rally®

The Rally® digital experience is designed to help you achieve your health goals, and you may earn Rally Coins that you can use for a chance to win rewards. Visit myuhc.com.



Quit For Life®

Get support to help you quit your way. The industry-leading tobacco cessation coaching program offered in collaboration with the American Cancer Society® includes outbound coaching calls, unlimited access to Quit Coach® staff during training and online learning community. To help you get started living tobacco-free, visit myuhc.com.



Real Appeal®

Evidence-based, virtual weight-loss program integrated into myuhc.com that provides you with tools and support to help you make small changes that may result in long-term weight loss. Get started at join.realappeal.com.



UnitedHealthcare Motion®

You may earn over \$1,000 per year in your health savings account (HSA) or health reimbursement account (HRA) by meeting daily walking goals. Your covered spouse is also eligible to earn incentives with Motion. Visit unitedhealthcaremotion.com to get started.



Behavioral Health

If you need help navigating mental health, financial or legal concerns, take advantage of these resources — included in your health plan at no additional cost.

- **Employee Assistance Program (EAP):** 24/7 support. Reach an EAP consultant by calling 1-888-887-4114, TTY 711.
- **Sanvello:** Self-care, self-improvement and coaching. Download the app from the App Store® or Google Play™ to get started.
- **Live and Work Well:** Self-help, education and resources. Sign in to myuhc.com, then go to Coverage & Benefits > Mental Health.
- **Behavioral Health visits:** Behavioral health treatment, including regularly scheduled therapy appointments. Call 1-844-333-8728 to find a network provider or at myuhc.com > Find a Doctor > Behavioral Health Directory



Maternity Support

Maternity Support Program: Provides expectant mothers with nurse support from pregnancy through delivery. Visit myuhc.com.



Premium doctors

Your health plan helps you find a doctor with the UnitedHealth Premium® program. The program identifies those doctors who meet national standards for quality and local market benchmarks for cost efficiency.

Go to myuhc.com and click on Find a Doctor. Look for the **blue hearts**. ❤️❤️



Visit with a doctor 24/7 — whenever, wherever

With a Virtual Visit, you can talk—by phone¹ or video—to a doctor who can diagnose common medical conditions and even prescribe medications, if needed.²



Virtual Visits may make it easier than ever to get treated by a doctor

Whether using myuhc.com[®] or the UnitedHealthcare[®] app, Virtual Visits let you video chat with a doctor 24/7—without setting up additional accounts or apps. But, if you'd rather just speak with a doctor, you can simply do a Virtual Visit over the phone. With a UnitedHealthcare plan, your cost for a Virtual Visit is \$49 or less.³

Use a Virtual Visit for these common conditions:

- Allergies
- Flu
- Sore throats
- Bronchitis
- Headaches/migraines
- Stomachaches
- Eye infections
- Rashes
- and more

\$49_{cost}

An estimated 25% of ER visits could be treated with a Virtual Visit—bringing a potential \$2,000⁴ cost down to \$49.

Get started

Sign in at myuhc.com/virtualvisits | Call 1-855-615-8335
Download the UnitedHealthcare app

**United
Healthcare**

¹ Data rates may apply.

² Certain prescriptions may not be available, and other restrictions may apply.

³ The Designated Virtual Visit Provider's reduced rate for a Virtual Visit is subject to change at any time.



More than a health plan — a personalized experience



Whatever your health plan questions and care needs are, you can count on any of our experts to help with answers and guidance.

Feel the support of a team that's dedicated to helping you

- Understand your benefits and claims
- Talk through your bill or payment
- Avoid overpaying, find the right care and cost options
- Get answers to your pharmacy questions
- Maximize your health savings
- Take advantage of all your plan's health and well-being benefits



24/7 support

Connect with a registered health care professional anytime by calling the number on your health plan ID card.

Get started

Sign in to myuhc.com® and click on Call or Chat

**United
Healthcare**

This service should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room.
The information provided through the program is for informational purposes only and provided as part of your health plan. Wellness nurses, coaches and other representatives cannot diagnose problems or recommend treatment.

Find care that fits your budget with help from myuhc.com

When you're deciding where to go for care, take a look at cost as well as quality and convenience. Often, you can get the care you need—and save money at the same time. Just go to myuhc.com* to:

Find and compare costs

Compare costs for providers and services in your network, including doctors, behavioral health resources, hospitals, office visits, labs, convenience and urgent care clinics and more. For minor health concerns, you can register for a Virtual Visit* and pay \$50** or less to talk to a doctor on your phone or computer.

Get personalized estimates

Before your visit, you can generate an out-of-pocket estimate based on your specific health plan status.

Did you know?

You could pay an average of

36% less

for care by checking your costs on myuhc.com¹



Get started at myuhc.com



*Check your official health plan documents to see what services and providers are covered by your health plan.

**The Designated Virtual Visit Provider's reduced rate for a virtual visit is subject to change at any time.

¹United Healthcare Internal Claims Analysis, 2016.

All United Healthcare members can access a cost estimate online or on the mobile app. None of the cost estimates are intended to be a guarantee of your costs or benefits. Your actual costs may vary. When accessing a cost estimate, please refer to the Website or Mobile application terms of use under Find Care & Costs section.

Virtual Visits phone and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual

Health Savings Account

Administered by Wex



Meeker and Wright Special Education Cooperative is continuing to offer the option for Health Savings Accounts (HSA) for all employees participating in the **Meeker and Wright Special Education Cooperative** health plan. The HSA balance can be used to pay for qualifying medical expenses during the year or saved for retirement.

| | |
|---|--|
| HSA annual contribution limits | Single: \$3,650 Family: \$7,300 |
| HSA catch-up contribution Ages 55+ | \$1,000 |

There are many benefits of an HSA, such as any contributions are tax free, and any balance in the HSA belongs to the employee. Because of the favorable tax status, other eligibility requirements apply. An employee cannot be covered under any other non-HSA qualified health insurance, such as a spouse's plan or Medicare and cannot be claimed as a tax dependent on someone else's tax return.



Flexible Spending Accounts (FSA)

Administered by Wex



Out-of-pocket health care and dependent care expenses can add up quickly. Ordinarily these expenses are paid with after-tax dollars. A Flexible Spending Account allows employees to pay for dental, vision and/or dependent day care expenses using pre-tax dollars. The money set aside in a flexible spending account is not subject to Social Security, federal or state income taxes.

Health Care FSA

If an employee is enrolled in the Medical Plan through **Meeker and Wright Special Education Cooperative**, they can also enroll in a Flexible Spending Account (FSA). This account allows an employee to set aside pre-tax dollars to pay for eligible medical, dental and vision expenses. Employees who are enrolled in the FSA may contribute up to \$2,850 per year on a pre-tax basis. **For employees in the HSA plans the FSA dollars are limited to Dental and Vision expenses.**

- Expenses must be incurred by you, your legal spouse, or your other eligible dependents.
- **The maximum calendar year contribution is \$2,850.**
- Only expenses incurred during your participation in the plan are eligible for reimbursement.
- Your participation in the reimbursement account ends when you leave **Meeker and Wright Special Education Cooperative** or you no longer meet the eligibility requirements.
- You may submit claims for expenses incurred after your termination date only if you elect COBRA continuation coverage and make the required contributions.

Dependent Care FSA

This account allows an employee to set aside pre-tax dollars to pay for eligible dependent care expenses. The maximum contribution amount is \$5,000 (**\$2,500** if married and file taxes separately). The deadline for sending in Dependent Care FSA claims that were incurred during the Plan Year, is March 31st.

- Eligible dependents are your children who are under age 13 or your eligible dependents of any age who are mentally or physically handicapped and incapable of caring for themselves. Care can be given in your home or in a facility outside of your home.
- **The maximum contribution is the lesser of: \$5,000 per calendar year, per family (or \$2,500 if married and filing taxes separately), or the lowest earned income of you or your spouse.**

Estimate expenses carefully. IRS rules require any money remaining in these accounts at year-end be forfeited

If an employee wants to participate in the Full Health Care, Limited Health Care and/or Dependent Care FSA for 2022, they must enroll during the annual enrollment period, even if they participated the prior year.

MAWSECO Vendor List



MAWSECO
MEEKER AND WRIGHT SPECIAL EDUCATION
COOPERATIVE #0938-52
 PO Box 1010
 720 9th Avenue
 Howard Lake, MN 55349

Melissa Hanson
 Executive Director
 (320) 543-1122 Voice or TDD
 Fax (320) 543-1121
 E-mail:
 mhanson@mawseco.k12.mn.us

MAWSECO 403(b)/457(b) List of Official Vendors:

Please note: you are able to use any account representative you wish to use, they would just need to be an official representative for one of our approved vendors below.

For MAWSECO matching funds information, please contact the HR Coordinator for eligibility and/or review your master contract / individual contract with Meeker & Wright Special Education Coop.

| Official Vendor | Link to website to find an advisor: |
|---|---|
| ❖ Ameriprise | https://www.ameripriseadvisors.com/ |
| ❖ Aspire | https://www.aspireonline.com/plan-types/403(b)-plan/k-12 |
| ❖ AXA Equitable | https://equitable.com/find-financial-professional |
| ❖ EFS Advisors | https://efsadvisors.com/find-advisor/ |
| ❖ Horace Mann | https://www.horacemann.com/locator |
| ❖ Minnesota State Retirement System (MSRS) 457(b) | https://www.msrs.state.mn.us/about-mndcp |
| ❖ Reliastar/Voya | https://www.voya.com/find-professional |
| ❖ Thrivent Financial | https://www.thrivent.com/connect-with-us/ |
| ❖ VALIC/AIG Retirement Solutions | https://www.aigrs.com/find-an-advisor |

Please complete the Salary Reduction Form and return it to the HR Coordinator in the Business Office if you would like to participate in a 403(b)/457(b) or change your elections.

Salary Reduction Agreement

Salary Reduction Agreement for 403(b)/403(b) Roth/457 TSA

Meeker & Wright Special Education Coop #0938
MAWSECO

Part 1. Employee Information

Name Social Security # Birth Date
Pay periods per year Requested Start Date Bargaining Group

Part 2. Contribution Information (fill in all that apply)

| Salary Reduction | | | | Service Provider | Employee | Contribution | Employer Match | |
|------------------|----------------------|----------------------|----------------------|----------------------|--|------------------------------------|---------------------------------------|---------------------------|
| Type | New | Change | Stop | | Salary Reduction Amount/Percent Per Pay Period | Annualized Salary Reduction Amount | Employer Match/Percent per Pay Period | Annualized Employer Match |
| 403(b) | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 403(b) | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 403(b) Roth | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 403(b) Totals | | | | | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

Part 4. Agreement

| | |
|---|---|
| <p>By signing this Agreement, Employee agrees to modify his/her salary as indicated above and Employer agrees to contribute this amount on Employee's behalf into the 403(b)/403 Roth/457 annuity(ies) or custodial account(s) selected by the Employee. It is intended that the requirements of all applicable state and federal tax rules and regulations (Applicable Law) will be met. The Employee understands and agrees that this Agreement:</p> <ol style="list-style-type: none"> 1. Is legally binding and irrevocable with respect to amounts paid or available while it is in effect; 2. May be terminated at any time for amounts not yet paid or available, and that a termination request is permanent and remains in effect until a new salary reduction agreement is submitted; 3. Is effective only for amounts not yet earned or made available in accordance with the Employer's administrative procedures. | <p>Employee further agrees that:</p> <p>He/she is responsible for determining that his/her salary reduction amount does not exceed the limits of the Applicable Law;</p> <p>He/she is responsible for the accuracy of the information provided by Employee, which is used in determining Employee's Maximum Annual Contribution limit; and Employer has no liability for any losses suffered by Employee that resulted from his/her participation in the 403(b)/403(b) Roth/457 program.</p> <p>Employee acknowledges that Employer has made no representation to Employee regarding advisability, appropriateness or tax consequences of the purchase of the 403(b) program. Nothing herein shall affect the terms of employment between Employer and Employee.</p> <p>This agreement supersedes all prior salary reduction agreements and shall automatically terminate if your employment with the Employer is terminated.</p> |
|---|---|

Salary Reduction Agreement

| | |
|---|--|
| <p>Important Information</p> <ol style="list-style-type: none"> 1. Employer does not choose the annuity contract(s) or custodial account(s) in which contributions are invested. 2. Employees are responsible for setting up and signing the legal documents to establish the annuity contract or custodial account. However, in certain group annuity contracts, Employer may be required to establish the contract. 3. In order to receive the expected tax results, Employees are responsible for investing in annuity contracts or custodial accounts that meet the requirements of Section 403(b)/403(b)/457 in the Internal Revenue Code. 4. Employees are responsible for naming a death benefit under the 403(b)/403(b) Roth/457 program. This is normally done at the time the annuity contract or custodial account is established. Beneficiary designations should be reviewed periodically. 5. Employees are responsible for all distributions and any other transactions with their service provider. All rights under the annuity contracts or custodial accounts are enforceable solely by the Employee, Employee Beneficiary or Employee's Authorized Representative. Employee must work directly with the service provider to transfer contract(s) or custodial accounts(s) to another service provider, begin distributions, and make loans, or otherwise access 403(b)/403(b) Roth/457 program assets. 6. Employees are responsible for determining that salary reductions do not exceed the allowable contribution limits under Applicable Law. Limits should be checked each year for scheduled increases. <p>Read Before You Sign:</p> <p>By signing this Agreement, you are declaring that the amount you have elected to withhold does not exceed the allowable contribution limits under Applicable Law. If selected in Part 2 above, you are declaring that you are eligible for one or both of the catch up elections as indicated. And you are accepting full responsibility for the amount you have elected to have withheld from your salary and contributed to the 403(b)/403(b) Roth/457 arrangement.</p> <p>Disclaimer – Other Fees: If an investment company does not agree to pay the third party administrator's fee associated with this employer's 403(b) Plan the fee, upon consent of the employer, shall be passed along to the 403(b) participant.</p> | <p>Part 5. Employee Signature</p> <p>I certify that I have read this complete Agreement and that my salary reductions do not exceed contribution limits as determined by Applicable Law. I also certify that I am eligible for the catch up election(s), if selected, under Part 2 above. I understand my responsibilities as an Employee under the 403(b)/403(b) Roth/457 programs, and I request that my Employer takes the action specified in this Agreement. I understand that all rights under annuity(ies) or custodial account(s) established by me under the 403(b)/403(b) Roth/457 program are enforceable only by me, my beneficiary or my authorized representative.</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="display: flex; justify-content: space-between;"> Employee Signature Date </div> <p>Part 6. Acknowledgement and Representative of Sales Agent/Representative</p> <p>I hereby acknowledge my responsibility to comply with the Employer's written directives regarding solicitation of Employees. I also acknowledge my responsibility to assist the Employee in determining the maximum contribution limits.</p> <p>Sales Agent/Representative (please print clearly)</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p>Phone</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p>Address</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="display: flex; justify-content: space-between;"> Signature Date </div> <p>Part 7. Employer Signature</p> <p>Employer hereby agrees to this Salary Reduction Agreement.</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p>Signature of Employer Representative</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p>Date</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p>Date Received in HR</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p>Date Received in Payroll</p> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> |
|---|--|

Dental Benefits

Administered by HealthPartners

Good oral care enhances your overall physical health, appearance, and mental well-being. Keep your teeth healthy and your smile bright with **Meeker and Wright Special Education Cooperative's** dental benefit plans through HealthPartners. Please see next page for Dental Coverage Cost.

| Services | In Network | Out-of-Network |
|---|---|---|
| Annual Deductible | \$50 / \$150 | \$50 / \$150 |
| Annual Benefit Maximum | \$1,000 | \$1,000 |
| Preventive Dental Services (cleanings, exams, x-rays) | 100% | 100% |
| Basic Dental Services I (fillings, Posterior Composite, Simple Extractions, Non-surgical periodontics, Endodontics) | 80% after deductible | 80% after deductible |
| Basic Dental Services II (Surgical periodontics, complex oral surgery) | 50% after deductible | 50% after deductible |
| Major Dental Services (Restorative crowns & onlays, bridges, dentures, partial dentures, dental implants) | 50% after deductible | 50% after deductible |
| Orthodontia Services | 50% after deductible up to a \$1,000 lifetime maximum | 50% after deductible up to a \$1,000 lifetime maximum |

Little Partners Benefit: Services for children 12 years old and under will be covered at 100% without deductible, annual maximum, or frequency limitations, when provided by a HealthPartners network dentist. Excluded services: Orthodontics, dental implants, and services that are not covered for all members.

Diabetes and Pregnancy: Additional periodontal services (exams, cleanings, scaling and root planning, and debridement) for our members who are diabetic and/or pregnant are covered at 100% in-network. Deductibles, annual maximums, and frequency limitations will be waived on these specific services for members referred into the program by a HealthPartners network dentist.

Vision Insurance (Employer Paid)

Administered by United HealthCare

Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone.

Your coverage from a United HealthCare doctor



MAWSECO

Vision Benefit Summary

Powered by UnitedHealthcare Vision Network

Customer Service and Provider Locator: (800) 638-3120

myuhcvision.com

UnitedHealthcare vision has been trusted for more than 50 years to deliver affordable, innovative vision care solutions to the nation's leading employers through experienced, customer-focused people and the nation's most accessible, diversified vision care network.

| Exam with Materials | |
|---|--|
| Benefit Frequency | |
| Comprehensive Exam(s) | Once every 12 months |
| Eyeglass Lenses | Once every 12 months |
| Frames | Once every 24 months |
| Contact Lenses instead of Eyeglasses | Once every 12 months |
| In-Network Services | |
| Copays | |
| Exam(s) | \$ 0.00 |
| Eyeglasses (lenses and frame) | \$ 0.00 |
| Contact lenses instead of Eyeglasses | \$ 0.00 |
| Frame Benefit (for frames that exceed the allowance, an additional 30% discount may be applied to the overage)¹ | |
| Private Practice Provider | \$130.00 retail frame allowance |
| Retail Chain Provider | \$130.00 retail frame allowance |
| Lens Options | |
| Standard Scratch-resistant Coating, Polycarbonate Lenses for Dependent Children (up to age 19) - covered in full. | |
| Contact Lens Benefit² (Formulary contact lenses refer to contact lenses available on our formulary contact list. Contact lenses not on this list are referred to as Non-Formulary. A copy of the list can be found at myuhcvision.com). | |
| Formulary contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay. | If you choose disposable contacts, up to 4 boxes are included when obtained from an in-network provider. |
| Non-Formulary contact lenses An allowance is applied toward the purchase of contact lenses outside the Formulary. Contact lens copay is waived. | \$105.00 |
| Necessary contact lenses³ | Covered in full after copay (if applicable). |
| Children's and Maternity Eye Care Benefit | |
| Members age 0-12 and members pregnant or breastfeeding are eligible for a 2nd exam. Members age 0-12 and members pregnant or breastfeeding are also eligible for a replacement frame and lenses if they have a prescription change of 0.5 diopter or more. The 2nd exam and replacement benefits are the same as the initial exam, frame and lens benefits. | |
| Out-of-Network Reimbursements (Copays do not apply) | |
| Exam(s) | Up to \$40.00 |
| Frames | Up to \$45.00 |
| Single Vision Lenses | Up to \$40.00 |
| Lined Bifocal and Progressive Lenses | Up to \$60.00 |
| Lined Trifocal Lenses | Up to \$80.00 |
| Lenticular Lenses | Up to \$80.00 |
| Elective Contacts instead of Eyeglasses ² | Up to \$105.00 |
| Necessary Contacts instead of Eyeglasses ³ | Up to \$210.00 |

Vision Insurance (Employee Paid)

Administered by VSP

Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone.

| Exam | In-Network Coverage (Using a Network Provider) | Out-of-Network Reimbursement (Using a Non-Network Provider) |
|--|---|--|
| Frequency | 12 months | |
| Benefit | \$20 Exam Copay | Reimbursed up to \$45 |
| Materials / Eyewear (Either Glasses or Contacts) | | |
| Standard Corrective Lenses Single vision | \$20 copay | \$30 allowance |
| Lined bifocal | \$20 copay | \$50 allowance |
| Lined trifocal | \$20 copay | \$65 allowance |
| Standard Progressive | \$20 Copay | \$50 allowance |
| Frames | | |
| Frequency | 12 months | |
| Allowance | Up to \$150 plus 20% off | Reimbursed up to \$70 |
| Lenses | | |
| Elective | Up to \$150 | Reimbursed up to \$105 |
| Necessary | \$20 Copay | Reimbursed up to \$210 |

Voluntary Vision Coverage Cost

Administered by VSP

| 2022 Vision Rates | |
|----------------------|---------------|
| Plan | Employee Cost |
| Vision Single | \$8.74 |
| Vision EE + One | \$13.99 |
| Vision EE + Children | \$14.28 |
| Vision EE + Family | \$23.02 |



Life and Accidental Death & Dismemberment Insurance

Insured by National Insurance Services



Group Life Insurance Benefit Summary

Group #: 026480, Mawseco Coop District 938

Policy: Madison National Life Insurance Company, Inc., 3335 **Original Effective Date:** 2/1/1997

| Class # | Class Title and Eligibility (Minimum Hour Requirement) | Basic Life and AD&D | Dependent Life |
|---------|--|---------------------|----------------|
| 01 | Business Manager (30 hours per week) | \$100,000 | Yes |
| 02 | Management and Licensed Personnel (30 hours per week) | \$75,000 | Yes |
| 03 | Classified Staff (30 hours per week) | \$50,000 | Yes |
| 04 | Special Education Coordinator/Supervisors (30 hours per week) | \$100,000 | Yes |
| 05 | Part-Time Management & Licensed Personnel (20 hours per week) | \$75,000 | Yes |
| 06 | Part-Time Special Education Coordinator/Supervisors (20 hours per week) | \$100,000 | Yes |
| 07 | Director (30 hours per week) | \$150,000 | Yes |
| 08 | Administrative Assistants (30 hours per week) | \$75,000 | Yes |

| | |
|---|--|
| Dependent Life Child Limiting Age: 19 or 23 if full-time student | Spouse \$2,000 Infant \$100 Child \$1,000 |
|---|--|

| | |
|---|--|
| Eligibility/Effective Date of Individual Coverage | First of month following Date of employment |
| Employee Contribution | Life Classes 01-04, 07-08: 0% Classes 05-06: Pro-rated based on full-time equivalency Dependent 100% |

Life and Accidental Death & Dismemberment Insurance

Insured by National Insurance Services



| | |
|---|---|
| Participation Requirement | <p>Life Classes 01-04, 07-08: 100% Classes 05-06: 0% Dependent 0% LOB: DLF Effective Date: 02/01/2021 Participation calculation: $29/100 = 29.00\%$</p> <p>The following participation requirements have not been met for Joinder Participation: The enrolled total: 29.00% is less than the required EOI participation: 30.0% Classes: 05, 06 Class Description: PART-TIME MANAGEMENT & LICENSED PERSONNEL, PART-TIME SPECIAL EDUCATION COORDINATOR/SUPERVISORS LOB: LIF Effective Date: 02/01/2021 Participation calculation: $2/2 = 100.00\%$</p> <p>Participation requirements have been met.</p> |
| Reduction Schedule | <p>Life Basic Life and Basic AD&D Insurance reduces to 50% upon attainment of age 70 and terminates at retirement. Dependent Dependent Spouse Basic Life Insurance reduces to 50% upon the Insured Spouse's attainment of age 70 and terminates upon the Insured Employee's retirement. Dependent Child Basic Life Insurance terminates upon the earlier of the Insured Child's attainment of the limiting age or the Insured Employee's retirement.</p> |
| Contract Employee Termination or Retirement | Coverage terminates at the earlier of retirement or expiration of the current contract year. If you terminate mid-contract, coverage terminates the date you last worked. |
| Non Contract Employee Termination | Coverage terminates on the date you last worked |
| Accelerated Death Benefit | Included |

Life and Accidental Death & Dismemberment Insurance

Insured by National Insurance Services



| | |
|--|--|
| Guarantee Issue | Life Classes 01, 04: \$100,000 Classes 02, 08: \$75,000 Class 03: \$50,000 Class 05: \$0 if participation in classes 05 and 06 combined is less than 60%; \$75,000 if participation in classes 05 and 06 combined is 60% or higher Class 06: \$0 if participation in classes 05 and 06 combined is less than 60%; \$100,000 if participation in classes 05 and 06 combined is 60% or higher Class 07: \$150,000 Dependent \$0 if group participation is less than 30%; \$2,000 if group participation is 30% or higher |
| EOI Requirements | Late entrants Not enrolled within 31 days of eligibility, increases, and amounts exceeding the Guarantee Issue |
| Termination & Continuation of Coverage | Coverage may continue, with payment of premiums during: -FMLA -Sick Leave - 120 working days -Military Leave - 15 days |
| Minnesota Continuation | 18 Month Minnesota Continuation Applies to Life |
| Minnesota Continuation and Retirement | MN Continuation applies to retiring employees. MN Continuation runs concurrently with any other Retiree coverage. |
| Conversion Provision | Included - must apply within 31 days |
| Waiver of Premium Provision | Disabled prior to age 60 Elimination period - 9 months Waiver of premium terminates at age 65 |
| Beneficiary Administration | Employers should request regular updates and maintain for their own records. Employees should also maintain a copy of the most recent beneficiary form for their records. |
| EAP | Yes |
| Billing Information | Billing Method: List Billed Date Census Last Received: 12/29/2020 |
| Renewal Date | 2/1/2023 |

Long-term Disability

Insured by National Insurance Services



Group Long Term Disability Insurance Benefit Summary

Group #: 026480, Mawseco Coop District 938

Policy: Madison National Life Insurance Company, Inc., 0356 **Original Effective Date:** 11/1/1993

| Class # | Class Title and Eligibility (Minimum Hour Requirement) | Maximum Annual Covered Salary / Maximum Monthly Benefit | Benefit | Elimination Period |
|---------|--|---|---------|------------------------------|
| 01 | Administrators, Teachers, Clerical, Social Workers, Aides and All Other Specified Employees (600 hours per year) | \$159,996 / \$8,889 | 66-2/3% | 90 consecutive calendar days |

| | |
|---|---|
| Eligibility/Effective Date of Individual Coverage | Date of Hire |
| Employer Contribution | 100% |
| Participation Requirement | 100% |
| Benefit Duration | To Age 65, reduced duration after age 61 |
| Definition of Disability | Total |
| Cumulative Elimination Period | 10 Working Days; allows return to work for a limited time without beginning the day elimination period over again |
| Minimum Monthly Benefit | \$50 |
| Calculation Method | Standard - Non-Contract Day |
| Pre-Disability Earnings Definition | Base Pay Include: service increment pay |
| Pre-Existing Conditions Exclusion | If you are treated for a medical condition in the 3 months prior to your effective date, any disability relating to that condition will not be covered until you have been insured for 12 months. |
| Terminations & Continuation of Coverage | Coverage may continue, with payment of premiums during: -FMLA -Employer Paid Sick Leave: 120 sick leave days |
| Contract Employee Termination or Retirement | Coverage terminates at the earlier of retirement or expiration of the current contract year. If you terminate mid-contract, coverage terminates the date you last worked. |

Long-term Disability

Insured by National Insurance Services



| | |
|--------------------------------------|--|
| Non Contract Employee Termination | Coverage terminates on the date you last worked |
| Own Occupation | 24 months following the end of the Elimination Period |
| Sick Pay Coordination | Disability benefit is offset by sick pay |
| Recurrent Disability | Any two periods of total disability from the same cause will be combined as one benefit period if they are separated by a recovery period of less than 6 months. |
| Rehabilitation Provision | Employee Only |
| Maternity Coverage | Included |
| Survivor Benefit | 3x LMB |
| Limitations (Mental/Substance Abuse) | 24 months per Occurrence unless hospital confined |
| Deductible Income (SS Integration) | Full Family; Employee & dependent SS disability or retirement benefit is considered an offset. General Freeze; Automatic or other general cost of living increases in "other specified income" will not cause a reduction in the LTD benefit. |
| Billing Information | Billing Method: List Billed Date Census Last Received: 12/29/2020 |
| EAP | Yes |
| Renewal Date | 2/1/2026 |

This summary of benefits is meant to be an overview of the Policy only. Please refer to the Certificate for a full explanation of your plan's benefits, exclusions, limitations, and reductions. Should there be any discrepancy between this outline and the Certificate, the Certificate will prevail.

Employee Assistance Program

Insured by National Insurance Services



Client Focused. Solution Driven.



Embedded Employee Assistance Program (EAP) with Claimant Assist
Support for Employees* with Life or Disability Insurance Through National Insurance Services



The EAP Program

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

Your EAP Service Provider

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

The EAP Process

When you access the EAP, LifeWorks counselors listen and take action toward finding solutions. The next step may include meeting with a mental health counselor for up to three face-to-face visits, negotiating health insurance benefits, or referrals to community resources for legal and financial services.

Referrals and Resources

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

Claimant Assist

NIS's Claimant Assist program offers special services to Long Term Disability claimants or Life Insurance

(over)

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

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

EAP Services Are Available to You Two Ways:

Phone: 866.451.5465
Online: www.niseap.com

Claimant Assist Services Are Available:
866.472.2734

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

© AP/National Insurance Services

#137.ee.rev.8.21

Employee Assistance Program

Insured by National Insurance Services



Client Focused. Solution Driven.

beneficiaries at no charge. If you have Disability insurance coverage through NIS, our Long Term Disability Claimant Services are available to guide and counsel claimants and their immediate family members. If you have Life insurance coverage through NIS, our Beneficiary Services Program provides counseling and assistance to beneficiaries when faced with the challenge of coping with loss.

Virtual Fitness

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

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

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

Up to three in-person assessment and counseling sessions.

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

Your EAP and Claimant Assist Administrator:



134 North LaSalle Street, Suite 2200
Chicago, IL 60602

Telephone Assistance:

EAP: 866.451.5465

Claimant Assist: 866.472.2734

Online:

www.niseap.com

Virtual Fitness

Insured by LifeWorks

Improve employee health and wellness with virtual fitness

LIFT session



Introducing LIFT session

LIFT session, a leading virtual fitness provider, has built a platform where users can work out on their own with personalized programs and access coaches if they have questions, or choose to work out under the live supervision of a coach online in 1-1 personal or group sessions.

LIFT provides your people an easily accessible, effective, and affordable way to reach their fitness goals anytime, anywhere for better health and wellbeing.

Why virtual fitness works

Physical activity is a vital part of employee health and wellbeing. Fitness improves mental and physical health, resulting in healthier, happier, and more productive employees. Providing your workforce with a turnkey fitness program that fits their schedule and lifestyle is important, which is why virtual fitness works. Combining technology and live coaches who interact with users creates an environment where users are held accountable, workout safely at maximum efficiency, achieve results faster, and have fun! LIFT works because it is convenient with anytime, anywhere access to programs and experts who keep users motivated and accountable, and removes all the complexity related to working out.



Virtual Fitness

Insured by LifeWorks

LIFT session virtual fitness is available through your LifeWorks Employee Assistance Program (EAP)

Included in the EAP

Automated fitness journeys. Built by industry experts to help users achieve their fitness goals. An automated journey is a six-week program with three 30 minute automated sessions per week.

Included in Wellness Add-on

- Users can chat live with certified coaches to receive customized fitness recommendations, personalized guidance and monitoring. Coaches can answer questions about fitness, nutrition, sleep, and how to use the app/platform.
- LIFT Global Challenges are pre-defined wellness challenges based on LIFT automated fitness journeys. After logging in to the LIFT Session app, users opt-in to monthly challenges and compete in a friendly environment with users across the globe.*

Add-on fitness services for your organization

Corporate Challenges – Based on LIFT Group Training, Corporate Challenges are a great way to kick-start a fitness program at your organization. Both teams and individuals can participate and earn points for each session they complete. Challenges are managed by LIFT and kick-off with hosted webinars to engage your workforce. Challenge dashboards track participation and standings.

Group Training – Live training with LIFT coaches and a small group of participants connected virtually. Coaches ensure proper form and intensity during workouts via real time two-way communication. Programs vary to keep participants engaged and motivated.

*Wellness Silver and Gold come with one automated LIFT session challenge per year. If you want to provide more than one, please let us know as it may affect pricing.



NEW fee for service offering: Private Broadcast Classes

LIFT Private Broadcast Classes are a perfect solution for organizations looking to improve their employees' health and wellness, especially in this pandemic climate, but also in the new digital workplace.

How it works:

- LIFT Private Broadcast Classes are live, online classes led by world-class instructors.
- With a wide variety of class types such as mindfulness, mobilization, strength, yoga and much more, organizations have the liberty to choose what speaks to them most based on their specific wellness goals.
- Classes are 30 minutes in length, accommodate up to 3,000 participants, making them a great solution for both small and global organizations.
- Class schedules are entirely customizable and are accessible to all levels and require no equipment.



LIFT also offers 1-1 Personal Training for a completely customized fitness experience with a LIFT coach. Employees can purchase 1-1 Personal Training sessions directly in the LIFT session app.

Kick-start a fitness program at you organization today.

Engage your people with all that LIFT session has to offer. Speak with your LifeWorks Customer Success Manager.



© 2021 LifeWorks (US) Ltd.

Horace Mann Student Loan Solutions

Struggling with Student Loan Debt?

MAWSECO is here to help! We've partnered with Horace Mann to bring you easy-to-use online tools, knowledgeable loan coaches, and personal consultations to help you manage your student loan debt, apply for federal loan forgiveness, and get on a path toward a brighter financial future.

With Horace Mann Student Loan Solutions, you'll be able to:

- Learn more about recent updates to the Public Service Loan Forgiveness (PSLF) program
- Determine your best repayment plan & calculate your loan forgiveness potential
- Receive ongoing support and guidance

This program is complimentary for district employees. Learn more and get started by visiting <https://www.horacemann.com/student-loan-debt-help/signup/nis>

After you have created your no-cost Student Loan Solutions account, loan coaches are available to help you via phone, chat and email.

Employee Enrollment Application/Change/ Cancellation Request

Minnesota



☐ Enroll
☐ Cancel
☐ Change

☐ Address Change
☐ Name Change
Date of Change ____/____/____

To Be Completed By Employer

ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of application, 1) please review all sections and confirm the employee completed the appropriate information, 2) complete the information in this section and 3) provide your signature and today's date. If the employee is waiving coverage, do not submit the application but retain it for your records.

Company Name _____ Group # _____ Department # _____

| Plan Variation | | Reporting Code | | Benefit Level/Class Code, if applicable | |
|----------------|--------------|----------------|--------------|---|-------------------|
| Medical _____ | Vision _____ | Medical _____ | Vision _____ | Life/AD&D _____ | Suppl. Life _____ |
| Dental _____ | Life _____ | Dental _____ | Life _____ | Spouse Life _____ | Suppl. AD&D _____ |

☐ New Enrollment/Additions: (Check one)

Date of Hire ____/____/____ Requested Date of Coverage ____/____/____

☐ New Hire ☐ Status Change (PT to FT)

☐ Return from Leave/Layoff

☐ Birth ☐ Marriage ☐ Adoption

☐ Court ordered dependent

☐ Other (describe) _____

☐ COBRA/State Continuation start date _____ stop date _____

☐ Annual Open Enrollment Requested Effective Date of Enrollment ____/____/____

☐ Cancellations: Last Date of Employment ____/____/____

Requested Effective Date of Cancellation ____/____/____

☐ Cancel all coverage

☐ Cancel all listed below – Section B

Reason: (check one)

☐ Death ☐ Employee Terminated ☐ Divorce

☐ Moved out of service area

☐ Dependent reached dependent max age

☐ Other (describe) _____

Employee Type ☐ Union ☐ Salaried ☐ Active ☐ COBRA/State Cont. #Hours worked per week _____
☐ Non-union ☐ Hourly ☐ Retire Date _____

Signature _____ Date _____

A. Employee Information

Employer Position _____ Phone Number _____

Last Name _____ First Name _____ MI _____ Social Security Number¹ _____

Address _____ Apt # _____ City _____ State _____ Zip Code _____ Home/Cell Phone _____

Date of Birth ____/____/____ Sex ☐ M ☐ F Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Widowed Work Phone _____

Language Preference, if not English _____

Email Address (Required for Online delivery) _____ Race – Check all that apply (Optional)²

☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American

☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White

☐ Other–Please specify _____

I want to receive my UnitedHealthcare health plan documents (choose one): ☐ Online ☐ Paper mailing

Please review Electronic Delivery Consent Notice at www.uhc.com/legal.

Primary Physician³ _____ Existing Patient? ☐ Yes ☐ No Primary Dentist³ _____

Physician First & Last Name _____ Dentist First & Last Name _____

ID # _____ ID# _____

¹Your Social Security number (SSN) is requested to identify you and your family and to report your coverage status to the federal government. The IRS requires UnitedHealthcare to report this information. If you choose not to provide your SSN, you will likely be contacted by the IRS or UnitedHealthcare, asking you to verify your SSN for tax purposes.

²IMPORTANT: Please see employer representative as some plans require a Primary Physician (Primary Care) and/or a Primary Care Dentist (PCD) selection.

³Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination.

⁴For employees enrolling in a UnitedHealthcare medical plan

Coverage Provided by "UnitedHealthcare and Affiliates":

Medical coverage provided by UnitedHealthcare Insurance Company

Dental coverage provided by UnitedHealthcare Insurance Company

Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company

Life coverage provided by UnitedHealthcare Insurance Company

B. Family Information

List All Enrolling/Changing/Cancelling (Attach sheet if necessary)

| | | | | | | |
|--|---|---|--|----|--|---------------------------------|
| Check appropriate box <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change | Relationship ¹ Spouse /Domestic Partner | Last Name | First Name | MI | Sex <input type="checkbox"/> M <input type="checkbox"/> F | Date of Birth ____/____/____ |
| | Social Security Number ¹ | | Primary Physician ² Name: _____ ID# _____ | | Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Race – Check all that apply (Optional) ⁴ <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other–Please specify _____ | | Primary Care Dentist ² Name: _____ ID# _____ | | | | |
| Check appropriate box <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change | Relationship ¹ Dependent | Last Name | First Name | MI | Sex <input type="checkbox"/> M <input type="checkbox"/> F | Date of Birth ____/____/____ |
| | Social Security Number ¹ | | Primary Physician ² Name: _____ ID# _____ | | Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Race – Check all that apply (Optional) ⁴ <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other–Please specify _____ | | Primary Care Dentist ² Name: _____ ID# _____ | | | | |
| Check appropriate box <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change | Relationship ¹ Dependent | Last Name | First Name | MI | Sex <input type="checkbox"/> M <input type="checkbox"/> F | Date of Birth ____/____/____ |
| | Social Security Number ¹ | | Primary Physician ² Name: _____ ID# _____ | | Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Race – Check all that apply (Optional) ⁴ <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other–Please specify _____ | | Primary Care Dentist ² Name: _____ ID# _____ | | | | |
| Check appropriate box <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change | Relationship ¹ Dependent | Last Name | First Name | MI | Sex <input type="checkbox"/> M <input type="checkbox"/> F | Date of Birth ____/____/____ |
| | Social Security Number ¹ | | Primary Physician ² Name: _____ ID# _____ | | Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Race – Check all that apply (Optional) ⁴ <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other–Please specify _____ | | Primary Care Dentist ² Name: _____ ID# _____ | | | | |

¹Your Social Security number (SSN) is requested to identify you and your family and to report your coverage status to the federal government. The IRS requires UnitedHealthcare to report this information. If you choose not to provide your SSN, you will likely be contacted by the IRS or UnitedHealthcare, asking you to verify your SSN for tax purposes. ²IMPORTANT: Please see employer representative as some plans require a Primary Physician (Primary Care) and/or a Primary Care Dentist (PCD) selection. ³For some cases, such as Qualified Medical Child Support, additional documentation may be required. Please see employer representative for more information. ⁴Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination.

C. Product Selection

Please check the box for each coverage in which you or your dependents are enrolling.

If your employer offers a choice of plans, indicate which plan you are selecting. Indicate the dollar amount selected for the Life and Accidental Death & Dismemberment (AD&D), Supplemental Life, Short-Term Disability (STD), and Long-Term Disability (LTD) plans. Benefit offerings are dependent upon employer selection.

| Person | Medical | Dental | Vision | Basic Life/AD&D | Supp Life/AD&D | Voluntary AD&D |
|---|--------------------------------|--------------------------------|--------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|
| Employee | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> \$ _____ | <input type="checkbox"/> \$ _____ | <input type="checkbox"/> \$ _____ |
| Spouse/Domestic Partner | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> \$ _____ | <input type="checkbox"/> \$ _____ | <input type="checkbox"/> \$ _____ |
| Dependent | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> \$ _____ | <input type="checkbox"/> \$ _____ | <input type="checkbox"/> \$ _____ |
| Person | STD | LTD | STD Buy Up | LTD Buy Up | Salary \$ _____ Required only if | |
| Employee | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | Life, STD, or LTD based on salary | |
| Life Insurance Beneficiary Full Name and Address (if applying for Life Insurance with UnitedHealthcare) | | | | | | |
| Primary | | | | | | |
| Secondary | | | | | | |

D. Other Medical Coverage Information This section must be completed. (Attach sheet if necessary.)

On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical health plan or policy, including another UnitedHealthcare plan or Medicare? ☐ YES (continue completing this section) ☐ NO (skip the rest of this section)

Name of other carrier _____

| Other Group Medical Coverage Information (only list those covered by other plan) | Type (B/S/F)* | Effective Date | End Date | Name and date of birth of policyholder for other coverage |
|---|------------------|----------------|----------|--|
| Spouse Name: | | | | |
| Dependent Name: | | | | |
| Dependent Name: | | | | |
| Dependent Name: | | | | |

*B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (married)

S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.

F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

Medicare – Employee Information: If enrolled in Medicare, please attach a copy of your Medicare ID card.

☐ Enrolled in Part A: Effective Date _____ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)☐ Enrolled in Part B: Effective Date _____ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)☐ Enrolled in Part D: Effective Date _____ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work

Medicare – Spouse/Dependent Name: _____

☐ Enrolled in Part A: Effective Date _____ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)☐ Enrolled in Part B: Effective Date _____ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)☐ Enrolled in Part D: Effective Date _____ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work

*Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.

E. Waiver of Coverage

I decline coverage for:

- ☐ Myself
☐ Spouse
☐ Dependent Children
☐ Myself and all dependents

Declining coverage due to existence of other coverage:

- ☐ Spouse's Employer's Plan ☐ Individual Plan
☐ Covered by Medicare ☐ Medicaid
☐ COBRA from Prior Employer ☐ VA Eligibility
☐ Tri-Care
☐ I (we) have no other coverage at this time
☐ Other _____

I understand that by waiving coverage at this time, I will not be allowed to participate unless I qualify at a special enrollment period or as a late enrollee, if applicable, or at the next open enrollment period. I acknowledge that I have received the "Important Information" statement which is included with this form.

Employee Initials _____ Date _____

F. Signature

Your enrollment in the plan is expressly conditioned upon your acceptance of all terms and conditions contained in this enrollment application. If you do not agree to the following terms and conditions, you may not complete your enrollment.

TERMS AND CONDITIONS

As a condition of my and/or my dependents' participation in the plan, and in consideration for the privileges that come from participation in the plan, I hereby agree for myself and/or for my dependents as follows:

I recognize and understand that the plan contracts with physicians and other providers that make up the plan network. I recognize that all physicians and other providers that participate in the plan network are subject to credentialing under applicable State regulations and pursuant to the plan's network credentialing process. I understand that such credentialing includes a review of provider education, training and licensure. However, by participating in the plan I hereby acknowledge and accept that the plan is not a provider of medical services, and I am aware that obtaining or not obtaining medical care involves significant risks such as serious injury and even death. I acknowledge that the credentialing of physicians and other providers does not in any way reduce this risk. I agree to assume all risks and responsibility for, and hold the plan harmless from, any and all claims for damages, including personal injury or death, medical expenses, disability, lost wages, and loss of earning capacity which may be incurred or associated with medical treatment obtained through a participating physician or other provider. I recognize that all physicians and other providers that participate in the plan network are independent contractors and not the plan's employees or agents and are solely responsible for any malpractice, adverse outcomes, or any other claims arising from medical treatment rendered to me and my dependents. I HEREBY AGREE THAT THE PLAN IS NOT RESPONSIBLE NOR LIABLE FOR ANY ADVICE, COURSE OF TREATMENT, DIAGNOSIS OR ANY OTHER INFORMATION, SERVICES OR PRODUCTS THAT I OR MY DEPENDENTS OBTAIN THROUGH A PARTICIPATING NETWORK PHYSICIAN OR OTHER PROVIDER.

(continued on next page)

F. Signature (Continued)

I recognize and understand that the plan does not recommend, endorse or make any representation about the appropriateness or suitability of any specific tests, products, procedures, treatments, services, or opinions. I recognize that the plan, plan documents, and any health and wellness information provided by the plan, are not intended or implied to be a substitute for professional medical advice, diagnosis or treatment. I agree to confirm any medical information obtained from or through the plan with other sources, and will review all information regarding any medical condition or treatment with my physician. I HEREBY AGREE TO NEVER DISREGARD PROFESSIONAL MEDICAL ADVICE OR DELAY SEEKING MEDICAL TREATMENT BECAUSE OF SOMETHING I HAVE READ OR ACCESSED THROUGH THE PLAN.

I confirm that the information I have provided on this form is complete and accurate.

I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

I acknowledge that I have received the "Important Information" statement which is included at the end of this form.

I authorize UnitedHealthcare to obtain and disclose information in connection with eligibility for medical coverage as described in this form. This authorization shall be valid as long as I am continually insured with the insurer.

| | | |
|------|---|---|
| Date | Employee Signature for all applying and waiving | Spouse Signature (if applying for coverage) |
|------|---|---|

IMPORTANT INFORMATION

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how your plan operates and how it may affect you. In an ever-changing environment, the information can never be complete and we urge you to contact us if, after enrollment, your Certificate of Coverage or other materials do not answer your questions. Further information is available at www.myuhc.com or at the toll-free Customer Care number located on the back of your identification card or on other plan materials.

1. We do not provide health care services or make treatment decisions. We help finance and/or administer the health benefit plan in which you are enrolled. That means:
 - We make decisions about whether the health benefit plan you chose will reimburse you for care that you may receive.
 - We do not decide what care you need or will receive. You and your provider make those decisions.
2. We may enter into arrangements where another entity carries out some of our duties, but those entities must operate consistently with our commitment to your plan.
3. We may use individually identifiable information about you to identify for you (and you alone) procedures, products, and services that you may find valuable.
4. We contract with networks of physicians and other providers. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.
5. Physicians and other providers in our networks are independent contractors and are not our employees or agents. We do not control nor do we have a right to control your provider's treatment or plan.
6. We may enter into agreements with your physician or other provider to share in the cost savings that our approach may generate. We encourage providers in our network to disclose the nature of those arrangements with you. If they do not, we encourage you to talk to your provider about these arrangements.
7. We encourage physicians and other providers to talk with you about care you or your provider think might be valuable.
8. We will use individually identifiable information about you as permitted by law, including in our operations and in our research. We will use anonymous data for commercial purposes including research.

Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for coverage.

I (we) request the indicated group coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from earnings.

I (we) authorize all providers of health services or supplies and any of their representatives to give the following to the HMO/insurance company(ies): any available information about the health history, condition, or treatment of any persons named in this request. I (we) authorize the HMO/insurance company(ies) to use this information to determine eligibility for health coverage and eligibility for benefits under an existing policy.

I (we) also authorize the HMO/insurance company(ies) to give this information to its (their) representatives or to any other organization for the reason notified above. I (we) agree that this authorization is valid as long as I am continually insured with the insurer. I (we) know that I (we) have the right to ask for and to receive a copy of this authorization.

I understand that the Certificate of Coverage and other documents, notices, and communications regarding my health benefit plan may be transmitted electronically.

I (we) have not given the agent or any other persons any health information not included on the Request for Coverage. I (we) understand that the HMO/insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this Request for Coverage and any attachments.



866-451-3399

Health Savings Account (HSA) Data Collection Worksheet

Please complete and submit this worksheet to your employer. This is an internal document used by your employer for data collection purposes. Worksheets returned to WEX Health, Inc. cannot be processed.

*=Required Fields

Step 1: Account Holder Information

| | | | |
|--|---|---|--------------------------------|
| <input type="text"/> *Employer Name (Do not abbreviate) | | <input type="text"/> Employee ID Number | |
| <input type="text"/> *Account Holder Name (First, MI, Last) | | <input type="text"/> *Social Security Number | |
| <input type="text"/> *Physical Address (Cannot be PO Box) | | <input type="text"/> *City | <input type="text"/> *State |
| <input type="text"/> *Email Address | | <input type="text"/> *Zip | |
| <input type="text"/> *Date of Birth (mm/dd/yyyy) | <input type="text"/> *Hire Date (mm/dd/yyyy) | <input type="text"/> *Day Telephone | |

Step 2: HSA Election for Current Tax Year

| | |
|---|--|
| Employee Contribution Note: I understand my Health Savings Account (HSA) will be set up effective the first day of the month following the date this worksheet is signed. *Per Pay Period Amount: \$ <input type="text"/> (to be deducted each pay period) Employer Contribution: Check with your employer to determine if you will receive employer contributions. Both employee and employer contributions will be applied to your annual IRS maximum. | HDHP Coverage Level ("check one") <input checked="" type="checkbox"/> Single / <input type="checkbox"/> Family *HDHP Coverage Date: <input type="text"/> (mm/dd/yyyy) Note: There may be tax consequences if HSA contributions exceed the IRS governed limit. To determine the maximum HSA contribution for the current tax year visit www.wexinc.com . |
|---|--|

Step 3: Authorized Signature

By signing this application I represent that: 1) I am covered under a high deductible health plan (HDHP); 2) I am not covered by any other health plan that is not an HDHP; 3) I am not enrolled in Medicare; 4) I cannot be claimed as a dependent on another person's tax return; and 5) I will read and agree to the HSA Custodial Agreement and Disclosure Statement on the WEX Health, Inc. Participant Portal. I understand that if my spouse is enrolled in a general-purpose FSA (a non-HDHP), I am not eligible to contribute to an HSA. I understand my Health Savings Account will be set up effective the first day of the month following the date the Enrollment Application is signed. Further, I understand that my Health Savings Account cannot be effective prior to my HDHP coverage date.

| | |
|--|-------------------------------|
| <input type="text"/> *Signature of Account Holder | <input type="text"/> *Date |
|--|-------------------------------|



wexinc.com

866-451-3399

Flexible Spending Account (FSA) Data Collection Worksheet

Please complete and submit this worksheet to your employer. **This is an internal document used by your employer for data collection purposes. Worksheets returned to WEX Health, Inc. cannot be processed.**

*=Required Fields

Step 1: Participant Information

| | | | |
|-------------------------------------|-------------------------|-------------------------|----------------------------------|
| <input type="text"/> | | <input type="text"/> | |
| *Employer Name (Do not abbreviate) | | Employee ID Number | |
| <input type="text"/> | | <input type="text"/> | |
| *Participant Name (First, MI, Last) | | *Social Security Number | |
| <input type="text"/> | | <input type="text"/> | |
| *Participant Mailing Address | | *City | *State *Zip |
| <input type="text"/> | | <input type="text"/> | <input type="text"/> |
| Email Address | | Day Telephone | |
| <input type="text"/> | | <input type="text"/> | |
| *Date of Birth (mm/dd/yyyy) | *Hire Date (mm/dd/yyyy) | *Gender (M/F) | *Marital Status (Married/Single) |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

Step 2: Employee Premiums

If you have a payroll deduction for insurance premiums, eligible premiums will be deducted before taxes are calculated. You will automatically be enrolled in this portion of your Section 125 Plan. However, if you wish, you may opt out of the Employee Premium Conversion part of the Plan by contacting your HR Department and filling out the waiver form. **Note:** Insurance premiums are not eligible for reimbursement with your Medical or Limited Medical Spending Account.

Step 3: Enrollment and Election Information

*Plan Type (If enrolled in an HSA, you are not eligible to enroll in the Medical FSA. However, you are eligible for both the Limited Medical FSA and Dependent Care FSA if offered through your employer.)

*Annual Election (If employer funded, note "ER" next to amount):

*Number of Pay Periods (If enrolling mid-year, please enter the number of remaining pay periods within the plan year):

*Per Pay Period Amount (to be deducted each pay period):

*Date of First Payroll (mm/dd/yyyy):

*Participant Effective Date (mm/dd/yyyy):

*Pay Frequency (please check one):

| Medical FSA Limit set by employer | Dependent Care Account Limit set by employer up to IRS maximum | Limited FSA Limit set by employer if this plan type is offered |
|--------------------------------------|--|--|
| \$ <input type="text"/> | \$ <input type="text"/> | \$ <input type="text"/> |
| + <input type="text"/> | + <input type="text"/> | + <input type="text"/> |
| = <input type="text"/> | = <input type="text"/> | = <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Monthly | Semi-Monthly | Bi-Weekly 24 |
| | | Bi-Weekly 26 |
| | | Weekly |
| | | Other |

Step 4: Authorization

I authorize my employer to reduce my pay on a per-pay-period basis as indicated above. I understand my reduction is for one flex plan year and that I cannot change or revoke my election unless I experience a qualifying event in accordance with Internal Revenue Code Section 125 and submit my request within a reasonable amount of time as deemed by the IRS and my employer. I am aware of the plan's forfeiture provision and that my Social Security and federal unemployment benefits may be reduced because of my reduced salary for tax purposes. Further, I authorize the release of any information necessary to substantiate claims submitted against my Flexible Spending Account.

| | |
|------------------------|----------------------|
| <input type="text"/> | <input type="text"/> |
| *Participant Signature | *Date |

Step 5: Refusal (Note: Only complete this step if you are NOT electing to enroll in a Flexible Spending Account)

| | |
|-----------------------|----------------------|
| <input type="text"/> | <input type="text"/> |
| Participant Signature | Date |

**DENTAL ENROLLMENT FORM**8170 33rd AVENUE SOUTH, PO BOX 297
MINNEAPOLIS, MN 55440-0297

| | | | |
|---|---|--|---|
| NAME OF EMPLOYER Meeker & Wright Special Ed Coop #0938 | | GROUP NUMBER 25279 | SITE MAWSECO |
| DENTAL PLAN | <input type="checkbox"/> NEW HIRE <input type="checkbox"/> RETIREE <input type="checkbox"/> OPEN ENROLLMENT | <input type="checkbox"/> EARLY RETIREMENT <input type="checkbox"/> COBRA <input type="checkbox"/> LIFE EVENT | DATE OF FULL-TIME EMPLOYMENT: ____/____/20____ COVERAGE EFFECTIVE DATE: ____/____/20____ |

APPLICANT: COMPLETE ALL UNSHADED AREAS

| | | | |
|------------------------------------|--------|-------------------------------------|----------------------------------|
| APPLICANT'S LAST NAME (LEGAL NAME) | | DATE OF BIRTH ____/____/____ | |
| FIRST NAME | M.I. | <input type="checkbox"/> SINGLE | <input type="checkbox"/> MARRIED |
| STREET ADDRESS / APT NUMBER | | CITY | STATE |
| ZIP CODE | COUNTY | APPLICANT'S TELEPHONE Home: () - - | Business: () - - |

DENTAL PLAN SELECTED: (If choices are available)**WAIVING COVERAGE:**

- ☐ Coverage through other employer
☐ Other

Please sign

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR EMPLOYEE AND EACH DEPENDENT BEING COVERED

| NAME | SOCIAL SECURITY NUMBER | DATE OF BIRTH (M/D/YYYY) | RELATIONSHIP TO EMPLOYEE | SEX (M/F) |
|------|------------------------|--------------------------|--------------------------|-----------|
| | | | SELF | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Do any of the dependent(s) listed above reside at a different address from the applicant?

- ☐ YES ☐ NO If YES, list dependent(s) name and address:

At the time of your effective date with HealthPartners, will you, your spouse, and/or dependent(s) be insured by any other dental insurance company?

- ☐ YES ☐ NO If YES, please complete the Coordination of Benefits Form. Check which type: ☐ Group ☐ Individual



Enrollment Form with Dependent Data

For employer internal use only. DO NOT RETURN TO VSP.

Name of group (employer): _____

Employee last name, first name, middle initial: _____

Social Security Number: _____

Gender: ☐ male ☐ female

Date of birth (month/date/year): _____

Effective Date of Coverage: _____

Type of coverage selected:

- ☐ employee only
- ☐ employee and one dependent
- ☐ employee and child(ren)
- ☐ employee and family
- ☐ waive coverage

* Dependent Relationship: S= spouse, C= child, H= handicapped child, T= student

| dependent last name | dependent first name | gender | * Dependent Relationship | date of birth mm/dd/yyyy |
|---------------------|----------------------|--------|---|-----------------------------|
| | | | <input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | / / |
| | | | <input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | / / |
| | | | <input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | / / |
| | | | <input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | / / |
| | | | <input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | / / |
| | | | <input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | / / |
| | | | <input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T | / / |

Employee Signature: _____

Insurance Benefit Enrollment Form



Employee: Complete and return this form to your Benefits Administrator.

Benefits Administrator: Retain a copy of this form for your records and provide employee with a copy. Mail/scan original to:

National Insurance Services, Attn: Billing Department
250 S. Executive Drive, Suite 300, Brookfield, WI 53005-4273
Phone: 1.800.627.3660 Fax: 262.814.1397

Enter your information:

| | | | |
|--|---|--|---|
| Employer Name: MAWSECO COOP DISTRICT 938 | | NIS Group Number: 026480 | |
| Full Name (Last name, First name, Middle Initial): | | Date of Hire: | |
| Home Address: | | City: | State: Zip: |
| Social Security Number: | <input type="checkbox"/> Single <input type="checkbox"/> Married | U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No* | Date of Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Occupation/Title: | Date Benefit Eligible: | Hours worked per week: | Annual Salary: |

*If you are not a U.S. Citizen, please provide a copy of your Visa.

Insurance benefits:

| | |
|---|---|
| <input type="checkbox"/> Elect <input type="checkbox"/> Decline | Long-Term Disability |
| <input type="checkbox"/> Elect <input type="checkbox"/> Decline | Basic Life and AD&D |
| <input type="checkbox"/> Elect <input type="checkbox"/> Decline | Dependent Basic Life (family unit): \$2,000 Spouse; \$1,000 Child(ren) / \$100 Infant |

Sign here (required whether electing or declining any coverage):

I have been given the opportunity to apply for group insurance and agree to accept or decline coverage(s) as noted above. If I am declining coverage(s), I understand that if my dependents or I decide to apply for coverage at a later date, Evidence of Insurability (medical questions) may be required at my own expense and the insurance company must approve coverage. If I have elected any coverage(s) above, I authorize my employer to make any required deductions, if any, from my salary to pay my portion of the insurance premium when my insurance becomes effective.

Warning: Any person who knowingly presents false information on an application for insurance may be guilty of a crime and subject to fines, confinement in prison, and/or denial of insurance benefits.

| | |
|------------|-------|
| Signature: | Date: |
|------------|-------|

More on other side ----->

| | | |
|------------|--|-------|
| Full Name: | Employer Name: MAWSECO COOP DISTRICT 938 | Date: |
|------------|--|-------|

Enter your Life Insurance beneficiary information:

Primary Beneficiary(ies) Attach additional pages if necessary.

| | | |
|------------|----------------------|--------------|
| Full Name: | Relationship to you: | % of Benefit |
| Full Name: | Relationship to you: | % of Benefit |
| Full Name: | Relationship to you: | % of Benefit |

Secondary Beneficiary(ies) Attach additional pages if necessary.

| | | |
|------------|----------------------|--------------|
| Full Name: | Relationship to you: | % of Benefit |
| Full Name: | Relationship to you: | % of Benefit |
| Full Name: | Relationship to you: | % of Benefit |

Spouse's Signature (May be required if choosing a primary beneficiary other than your spouse. Under state law a beneficiary other than your spouse may not be honored unless your spouse signs below. Please consult with your legal advisor before making such a designation.)

| | | |
|----------------|------------|-------|
| Spouse's Name: | Signature: | Date: |
|----------------|------------|-------|

Add spouse/dependent information:

Please provide the following information if electing Dependent Coverage. Attach additional pages if necessary.

| Full Name | Date of Birth | Social Security # | Full-Time Student? |
|--|---------------|-------------------|--|
| Spouse: _____ Date of Marriage: _____ | | | n/a |
| Child: _____ | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Child: _____ | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Child: _____ | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Child: _____ | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Child: _____ | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Legal Notices

Women's Health & Cancer Rights Act

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

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

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

Plan 1: \$1,000 Deductible, 20% Coinsurance, \$3,000 OOP (Individual: 20% coinsurance and \$1,000 deductible; Family: 20% coinsurance and \$2,000 deductible)

Plan 2: \$3,500 Deductible, 0% Coinsurance, \$3,500 OOP HSA (Individual: 0% coinsurance and \$6,750 deductible; Family: 0% coinsurance and \$13,500 deductible)

Plan 3: \$6,750 Deductible, 0% Coinsurance, \$6,750 OOP HSA (Individual: 0% coinsurance and \$5,000 deductible; Family: 0% coinsurance and \$10,000 deductible)

If you would like more information on WHCRA benefits, please call your **Plan Administrator at 612.417.6491 or esullivan@mawseco.k12.mn.us**.

Notification of Possible Federal Public Service Loan Forgiveness Eligibility (PSLF)

Minnesota Statutes Section 136A.1792, covers promotion of federal public service loan forgiveness programs. Please be aware that you may be eligible for federal public service loan forgiveness of the remaining balance due on certain federal student loans after you have made 120 qualifying payments on those loans while employed full-time by certain public service employers.

For detailed information including how to monitor your progress toward qualifying for PSLF, read the PSLF Questions and Answers documents at [StudentAid.gov/public service](https://studentaid.gov/public-service) or contact your federal loan servicer.

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 January 31, 2022. Contact your State for more information on eligibility –

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

| GEORGIA – Medicaid | MAINE – Medicaid |
|--|--|
| <p>A 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</p> | <p>Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711</p> <p>Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740. TTY: Maine relay 711</p> |
| INDIANA – Medicaid | MASSACHUSETTS – Medicaid and CHIP |
| <p>Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584</p> | <p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840</p> |
| IOWA – Medicaid and CHIP (Hawki) | MINNESOTA – Medicaid |
| <p>Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562</p> | <p>Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739</p> |
| KANSAS – Medicaid | MISSOURI – Medicaid |
| <p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884</p> | <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p> |
| KENTUCKY – Medicaid | MONTANA – Medicaid |
| <p>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: KIHIPPPROGRAM@ky.gov</p> <p>KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718</p> <p>Kentucky Medicaid Website: https://chfs.ky.gov</p> | <p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084</p> |
| LOUISIANA – Medicaid | NEBRASKA – Medicaid |
| <p>Website: www.medicicaid.la.gov or www.lidh.la.gov/la hipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p> | <p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p> |
| NEVADA – Medicaid | SOUTH CAROLINA – Medicaid |
| <p>Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900</p> | <p>Website: https://www.scdhhs.gov Phone: 1-888-549-0820</p> |

| | |
|--|---|
| NEW HAMPSHIRE – Medicaid | SOUTH DAKOTA - Medicaid |
| Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218 | Website: http://dss.sd.gov Phone: 1-888-828-0059 |
| NEW JERSEY – Medicaid and CHIP | TEXAS – Medicaid |
| Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 | Website: http://gethipptexas.com/ Phone: 1-800-440-0493 |
| NEW YORK – Medicaid | UTAH – Medicaid and CHIP |
| Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831 | Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669 |
| NORTH CAROLINA – Medicaid | VERMONT– Medicaid |
| Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100 | Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427 |
| NORTH DAKOTA – Medicaid | VIRGINIA – Medicaid and CHIP |
| Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825 | Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924 |
| OKLAHOMA – Medicaid and CHIP | WASHINGTON – Medicaid |
| Website: http://www.insureoklahoma.org Phone: 1-888-365-3742 | Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 |
| OREGON – Medicaid | WEST VIRGINIA – Medicaid and CHIP |
| Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075 | 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) |
| PENNSYLVANIA – Medicaid | WISCONSIN – Medicaid and CHIP |
| Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 | Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002 |
| RHODE ISLAND – Medicaid and CHIP | WYOMING – Medicaid |
| Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line) | 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 January 31, 2022, 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

HIPAA Special Enrollment Rights

Meeker and Wright Special Education Cooperative Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the **Meeker and Wright Special Education Cooperative** 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 30 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 30 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 **Elizabeth Sullivan - HR Coordinator** at **612.417.6491** or esullivan@mawseco.k12.mn.us.

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 **Meeker and Wright Special Education Cooperative**

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 **Meeker and Wright Special Education Cooperative** 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. **Meeker and Wright Special Education Cooperative** 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. However, please note that the \$6,750 Deductible Plan is NOT Credible. 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 the **Meeker and Wright Special Education Cooperative** coverage will not be affected. Your current coverage will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current the **Meeker and Wright Special Education Cooperative** coverage, be aware that you and your dependents 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 with **Meeker and Wright Special Education Cooperative** and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through **Meeker and Wright Special Education Cooperative** 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: | October 01, 2022 |
| Name of Entity/Sender: | Meeker and Wright Special Education Cooperative |
| Contact—Position/Office: | Elizabeth Sullivan—HR Coordinator |
| Office Address: | 720 9th Ave Howard Lake, Minnesota 55349-4545 United States |
| Phone Number: | 612.417.6491 |

Marketplace Notice

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: 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 9.5% 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.¹

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact **Elizabeth Sullivan**.

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.

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

PART B: Information About Health Coverage Offered by Your Employer

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

| | | | |
|--|--|---|---------------------------|
| 3. Employer name Meeker and Wright Special Education Cooperative | | 4. Employer Identification Number (EIN) (41-1304320) | |
| 5. Employer address 720 9th Ave | | 6. Employer phone number 612.417.6491 | |
| 7. City Howard Lake | | 8. State Minnesota | 9. ZIP code 55349-4545 |
| 10. Who can we contact about employee health coverage at this job? Elizabeth Sullivan | | | |
| 11. Phone number (if different from above) | | 12. Email address esullivan@mawseco.k12.mn.us | |

Prepared by:



Gallagher

Insurance | Risk Management | Consulting