2025

EMPLOYEE BENEFITS GUIDE

Dickinson PUBLIC SCHOOLS

Welcome to your 2025 Benefits!

Dickinson Public Schools strives to provide a balanced, comprehensive benefits program for their employees. The Dickinson Public Schools Employee Benefits program offers you and your family various benefits: Medical, Dental, Vision, HSA and FSA plans, as well as Life and Disability coverages. Please refer to Human Resources for a complete listing of all your employee benefits.

This booklet is designed to help you understand the coverages for this year. This is a reference for you and your family to make informed insurance decisions based on your specific needs. If you have questions, please contact your Human Resources Department.

WHO'S ELIGIBLE FOR COVERAGE?

All permanently employed Certified and Classified Staff Members working at least 20 hours per week are eligible for coverage on the first day of the month following the employee's first full month of employment. If you terminate employment or move to part-time employment your coverage will terminate on the last day of the month that the change/termination occurs.

Please note: It is important that you enroll in a timely manner. If you do not enroll within your first 30 days of employment, then you will not be eligible to enroll without a qualifying life event change until the next open enrollment period. Open enrollment will run from November 4th through November 18th and benefits will begin January 1, 2025.

MAKING CHANGES DURING THE PLAN YEAR

When you make a benefit election, it will remain in effect for the entire Plan year (January 1, 2025 through December 31, 2025). You may be able to make limited changes to your elections if you experience a "qualifying event". Qualifying events include, but are not necessarily limited to, the following:

- Marriage, divorce or legal separation
- Gain or loss of an eligible dependent for reasons such as birth, adoption, court order, disability, death or reaching the dependent child age limit
- Significant changes in employment or benefit coverage that affect you or your dependent's benefit eligibility

You have 30 days from the date of the qualifying event to request a change from HR. You will not be able to make any changes if you miss this deadline.

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Dickinson PUBLIC SCHOOLS

MEDICAL

The Company's Medical Plans are administered by Regence BlueCross BlueShield of North Dakota, and designed to help you maintain your health through preventive care services, access to an extensive network of providers, and affordable prescription medication. All eligible employees may enroll in the Your Blue Plan or HDHP Plan. These Plans use the Regence BlueCross BlueShield North Dakota network of providers.

TERMS TO KNOW

Copay— A fixed amount paid for receiving a specific healthcare service.
Deductible— The amount paid for covered services before the plan will pay.
Coinsurance— Employees' share of the cost for covered services, calculated as a percentage of the total eligible expenses.
Out-of-Pocket Maximum (OOPM)— Protects employees from major expenses with a maximum annual limit on the amount paid for covered services.
The OOPM includes the deductible, coinsurance and copayments, but not employee contributions. Once employees reach the OOPM, the plan pays 100% of covered services for the remainder of the year.

FIND A NETWORK DOCTOR

To find a network doctor and other useful tools, visit www.bcbsnd.com.

MEDICAL PLANS

BCBSND PLANS	Your Blue		HDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible				
Single	$500	$1,000	$1,650	$3,300
Single + Dependent	$1,000	$2,000	$3,300	$6,600
Two-Party (adult)	$1,000	$2,000	$3,300	$6,600
Family	$1,000	$2,000	$3,300	$6,600
Out-of-Pocket Maximum (includes deductible)				
Single	$7,500	$8,050	$8,050	$16,100
Single + Dependent	$15,000	$16,100	$16,100	$32,200
Two-Party (adult)	$15,000	$16,100	$16,100	$32,200
Family	$15,000	$16,100	$16,100	$32,200
Benefit Highlights: Your Cost Sharing Amounts				
Preventive Care	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Office Visits				
Primary Care	$20 copay	Covered 60% AD	Covered 80% AD	Covered 60% AD
Specialist	$40 copay	Covered 60% AD	Covered 80% AD	Covered 60% AD
Urgent Care	$50 copay then covered 80%		Covered 80% AD	
Emergency Room	Covered 80% AD		Covered 80% AD	
Inpatient & Outpatient Hospital	Covered 80% AD	Covered 60% AD	Covered 80% AD	Covered 60% AD
Mental Health				
Outpatient	First 5 hours covered 100%, then 80% AD	Covered 60% AD	Covered 80% AD	Covered 60% AD
Inpatient	Covered 80% AD	Covered 60% AD	Covered 80% AD	Covered 60% AD

PRESCRIPTIONS	Your Blue	HDHP
	Retail (34-day supply) & Mail Order (61-100 day supply)	**Retail (34-day supply) & Mail Order (61-100 day supply)**
Formulary	$10 + 20% to a maximum of $1,000	Covered 80% AD
Non-Formulary	$10 + 50% sanction	Covered 80% AD

AD = after deductible

For more details and to view official plan documents, please view our benefits app.

TELEHEALTH

Get care when and where you need it through your BCBSND Medical Plan. As a BCBSND member, you have access to Amwell's network of U.S. board-certified physicians. Whenever you need care, Amwell doctors are available 24/7 by mobile, web or phone.

WHAT CAN AMWELL TELEHEALTH HELP WITH?

Call Amwell to receive quality care, without setting foot in a doctor's office, for conditions such as:

- Cold
- Flu
- Bronchitis
- Respiratory Infections
- Sinus Infections
- Allergies
- Urinary Tract Infections
- Pink Eye
- And more!

SUPPORT HEALTH & WELLNESS

Not waiting for answers, diagnoses or care plans means you can heal faster, keep illness out of the office, and manage your health on your terms.

ELIMINATE BARRIERS TO CARE

Access at your fingertips with no appointments or wait times.

AFFORDABLE, EASY, CONVENIENT

- $0 COPAY (Your Blue)
- $64 COPAY (HDHP)

For more information, visit www.amwell.com or call 855-818-DOCS.

OTHER SERVICE COSTS

- Psychotherapy - Masters Level: $95
- Psychotherapy - Doctorate Level: $115
- Psychiatry - Initial Visit: $250
- Psychiatry - Follow Up (30 mins): $140
- Psychiatry - Follow Up (15 mins): $95
- Registered Dietitian: $68
- Lactation Consultant - Initial Visit (50 mins): $115
- Lactation Consultant - Follow Up Visit (25 mins): $69

amwell®

GET STARTED

1. Download the Amwell app and enroll now
2. Select BCBSND as your health plan
3. Enter your health plan information
   Service Key: BCBSND

AMAZON RX

A NEW WAY TO SAVE ON MEDICINE

HOME DELIVERY FROM AMAZON PHARMACY

Amazon Pharmacy offers a home delivery service that lets you easily order and quickly get your non-specialty medicines[1] delivered at home.

And as a member of Blue Cross Blue Shield of North Dakota, you get access to MedsYourWay™ prescription drug discount card pricing. The prescription discount card[2] gives you up to 80% savings[3] on brand and generic medicines and is seamlessly built into the Amazon Pharmacy experience. You can get the lowest cost available while saving time and money. Using the MedsYourWay discount card is not insurance; however, using it for covered medicines[4] may also count toward your out-of-pocket maximum.

SHOP

EASY TO USE

Amazon Pharmacy makes it easier because it's like shopping on Amazon.com:

- Easy sign-up, which includes the option to have your account auto-populated with your prescription history
- Option for 90-day fills
- Pharmacist on call 24/7
- Ability to manage your medicine and order history

SAVE

BUILT-IN DRUG DISCOUNT CARD

Some drugs may be available at lower prices with a discount card. MedsYourWay discount card pricing is built right into the Amazon Pharmacy experience.

- At checkout, you'll see the lowest cost available for your medicine. That's the price you'll pay.
- The MedsYourWay discount card pricing is not insurance; however, using it to purchase covered4 eligible medicines by your plan at Amazon Pharmacy may automatically count toward your benefit accumulators.

SHIP

FREE HOME DELIVERY

Skip the pharmacy line with home delivery.

- Free, fast delivery: Amazon Prime members get 2-day free shipping on most orders; standard free shipping for non-Amazon Prime members is 5-day but can be expedited to 2-day delivery for $5.99
- Real-time package tracking from order to delivery

You can sign up or learn more by going to amazon.com/bcbsndmeds and clicking "get started." For questions, call Amazon Pharmacy Customer Care at 855.206.0372, Monday through Friday 7 a.m. – 9 p.m. CT, and Saturday and Sunday 9 a.m. – 7 p.m. CT. For additional questions, please call the number on the back of your member ID card.

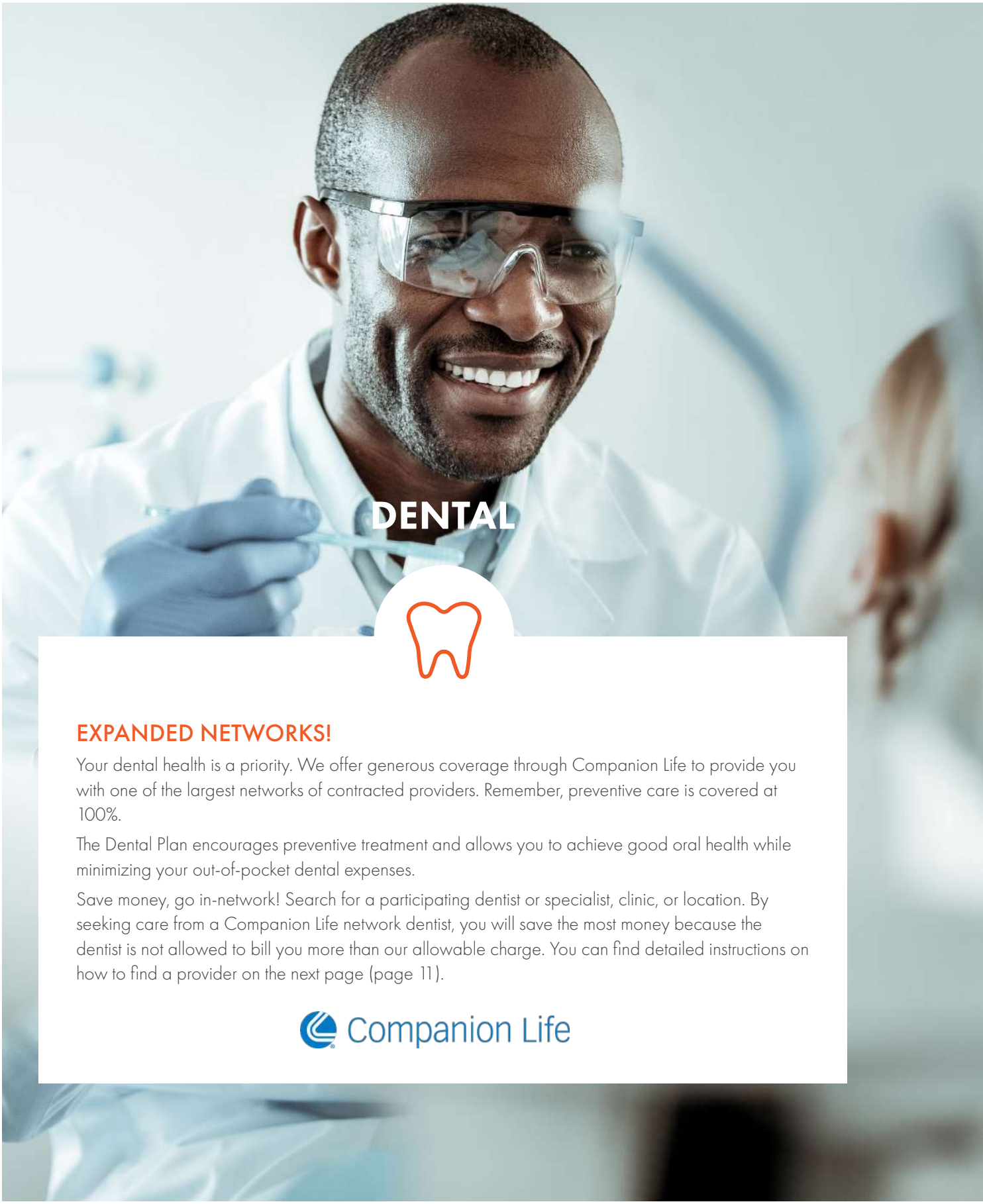
- Tap the camera (app) on your smart phone.
- Place your camera over the QR Code so you can see it clearly on your camera screen.
- A notice will show up at the top or bottom of the screen. Tap on it to open the QR Code.

[1] Amazon Pharmacy does not dispense Schedule 2 controlled substance drugs.

[2] MedsYourWay prescription drug discount card, administered by Inside Rx LLC, is not insurance. You are responsible for the cost of prescription(s) when using the card. Limitations apply.

[3] Average savings based on usage and Inside Rx data as compared to cash prices; average savings are up to 80% for all generics and 37% for select brand medicines. Restrictions apply.

[4] If your medicine has an unfulfilled requirement or is a non-preferred/non-formulary medicine, the cost may not count towards your out-of-pocket (accumulator) maximum. Typical requirements include prior authorization (PA) needed, quantity limit exceeded, or step therapy needed.



DENTAL

EXPANDED NETWORKS!

Your dental health is a priority. We offer generous coverage through Companion Life to provide you with one of the largest networks of contracted providers. Remember, preventive care is covered at 100%.

The Dental Plan encourages preventive treatment and allows you to achieve good oral health while minimizing your out-of-pocket dental expenses.

Save money, go in-network! Search for a participating dentist or specialist, clinic, or location. By seeking care from a Companion Life network dentist, you will save the most money because the dentist is not allowed to bill you more than our allowable charge. You can find detailed instructions on how to find a provider on the next page (page 11).

Companion Life

DENTAL

Dental Plan Summary	In and Out-of-Network*
Plan Year Deductible (Waived for Type 1 Services)	
Per Individual Family Limit	$50 Calendar Year Max 3 per family
Benefit Year Maximum	
Contract Year Maximum	$1,500 per person
Benefits & Services	
Type I: Preventive Services **Preventive Services do not count towards the annual maximum** Cleanings (2 per 12 months), exams, full mouth x-rays, fluoride treatments, space maintainers, emergency pain, radio-graphs, bitewings (1 per 12 months)	Covered 100%
Type II: Basic Services Restorations (amalgams & anterior resin, posterior resin), simple extractions, oral surgery, endodontics, periodontal maintenance, non-surgical periodontics, anesthesia	80% after deductible
Type III: Major Services Inlays, onlays, crowns, crown repairs, bridges, bridge repairs, dentures, denture repairs, implants	50% after deductible
Type IV: Orthodontia Child only, $1,500 lifetime maximum	50% after deductible

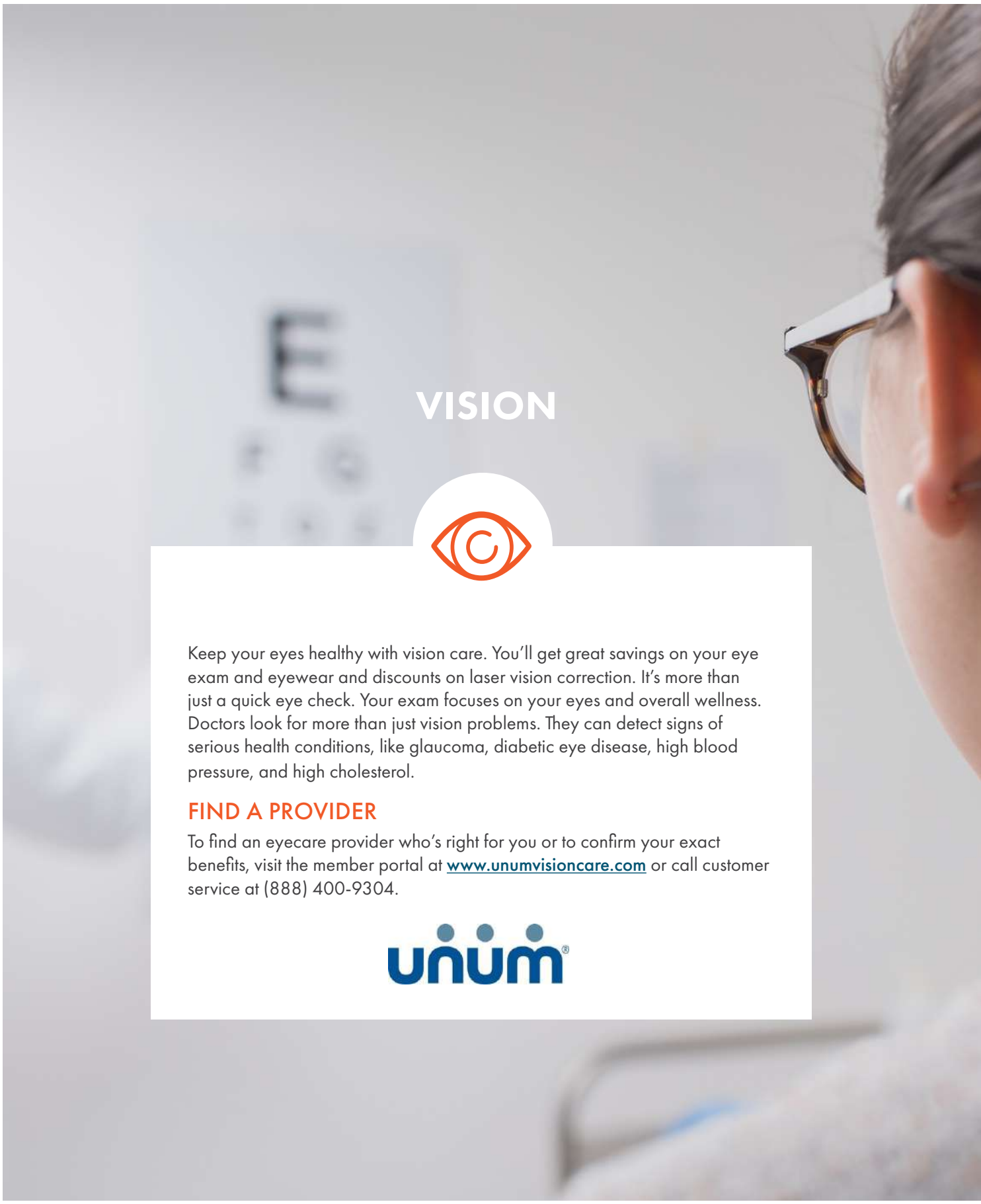
**Out of network benefits are paid at the 90th percentile of Reasonable & Customary charges.*

FIND A PROVIDER

There are two ways to find a provider within the expansive network offered. We recommend checking both ways to make sure the provider list you see is the most up-to-date.

1. Visit www.companionlife.com and click "Find a Dentist" on the upper right. The search results will pull from two different networks (United Concordia and Dentemax) to give you all provider options available.
2. Visit www.unitedconcordia.com and click on "Find a Dentist" on the upper right. The network we have access to is the Advantage Plus network.

Scan the QR code to visit our benefits app and learn more about your benefits.



VISION

Keep your eyes healthy with vision care. You'll get great savings on your eye exam and eyewear and discounts on laser vision correction. It's more than just a quick eye check. Your exam focuses on your eyes and overall wellness. Doctors look for more than just vision problems. They can detect signs of serious health conditions, like glaucoma, diabetic eye disease, high blood pressure, and high cholesterol.

FIND A PROVIDER

To find an eyecare provider who's right for you or to confirm your exact benefits, visit the member portal at www.unumvisioncare.com or call customer service at (888) 400-9304.

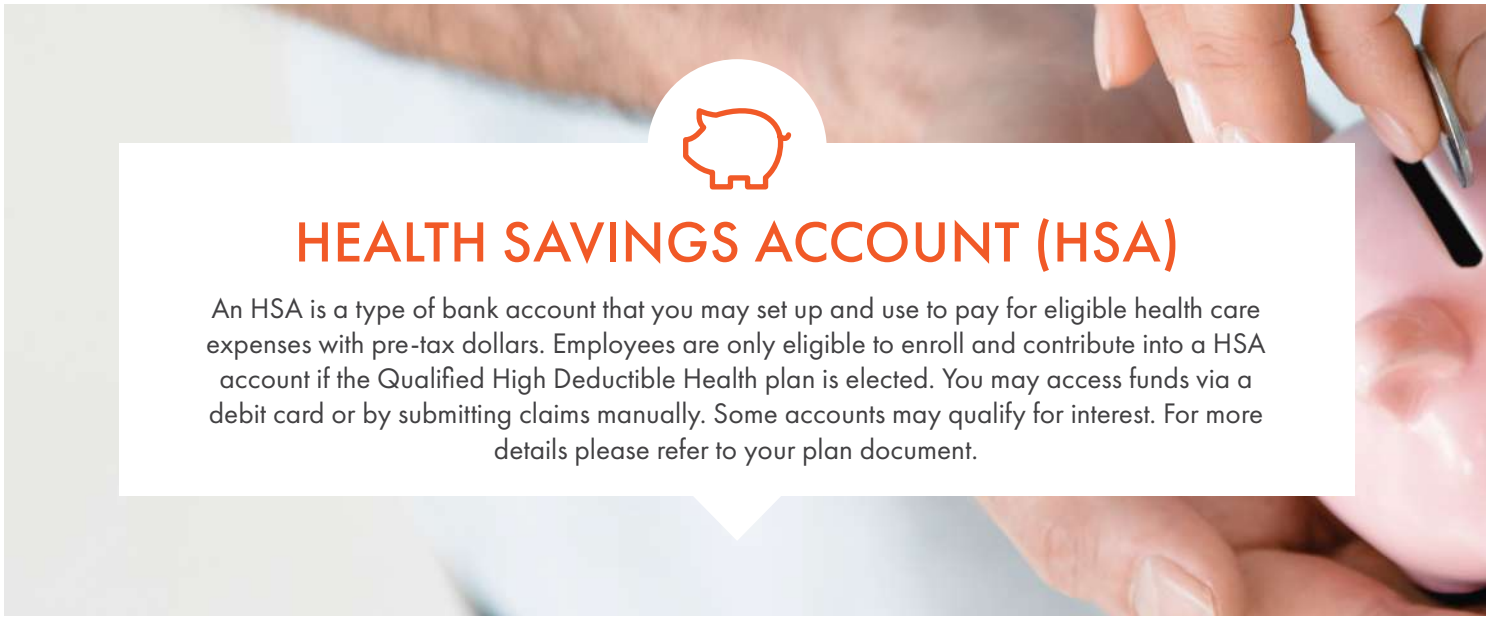
VISION PLAN

Unum Vision	In-Network Providers	Out-of-Network
Exams (once every 12 months)		
Vision Exam	$20 copay	Up to $40
Standard Plastic Lenses (once every 12 months)		
Single Vision	$20 copay	Up to $30
Bifocal	$20 copay	Up to $50
Trifocal	$20 copay	Up to $70
Lenticular	$20 copay	Up to $50
Standard Progressive	$85 allowance	Up to $50
Other Benefits		
Frames (once every 24 months) Members may select any frame available	$130 allowance	Up to $91
Contacts (in lieu of frames, once every 12 months)		
Elective	$130 allowance	Up to $130
Non-Elective	Covered	Up to $210
Standard Contact Lens fitting Exam Fee*	$40 copay	Not covered

**The standard contact lens fitting exam fee applies to a new or existing contact lens user who wears spherical disposable, daily wear, or extended wear lenses only.*

Login to www.unumvisioncare.com for a list of participating laser vision correction providers. Discounts are available with participating surgery providers across the country (not an insured benefit).

Scan the QR code to visit our benefits app and learn more about your benefits.



HEALTH SAVINGS ACCOUNT (HSA)

An HSA is a type of bank account that you may set up and use to pay for eligible health care expenses with pre-tax dollars. Employees are only eligible to enroll and contribute into a HSA account if the Qualified High Deductible Health plan is elected. You may access funds via a debit card or by submitting claims manually. Some accounts may qualify for interest. For more details please refer to your plan document.

TO QUALIFY FOR AN HSA YOU:

- Must be enrolled in a qualified High Deductible Health Plan (HDHP),
- Must not be covered by any other medical plan that is not a HDHP (such as a spouse's plan including the spouse's FSA unless it is a limited purpose FSA),
- Must not be entitled to benefits under Medicare, and
- Must not have received VA benefits in the last 3 months.

2025 MAXIMUM HSA CONTRIBUTIONS

The contributions from all sources may not exceed the annual maximum allowed or it will be subject to income tax. The maximum allowed annual contributions are:

- Individual - $4,300
- All other Tiers - $8,550
- Catch-up (Age 55+) - $1,000

If you are 55 and older you are allowed to contribute an additional $1,000 each year.

EXAMPLES OF QUALIFIED EXPENSES:

- Acupuncture
- Alcohol and Drug Rehab
- Ambulance
- Blood Pressure Monitoring Devices
- Chiropractor
- Contact Lenses
- Deductibles
- Prescriptions
- Dental Care
- Diabetic Supplies
- Eye exam and hardware
- Hearing Aids
- Home Healthcare
- Medical Supplies
- Orthodontia

EXAMPLES OF NON-QUALIFIED EXPENSES

- Cosmetic Surgery
- Diapers
- Exercise Equipment
- Hygiene Products

Your HSA account is governed by the IRS. Amounts used for non-qualified healthcare expenses are subject to income tax and a 20% penalty.

For a full list of eligible expenses, visit:
www.wexinc.com/insights/benefits-toolkit/eligible-expenses/

FLEXIBLE SPENDING ACCOUNTS (FSA)

There are two types of FSAs available to you: a Health Flexible Spending Account (FSA) and a Dependent Care Flexible Spending Account (DCFSA). Both accounts allow you to put aside pre-tax money to pay for the types of expenses listed below.

WHAT IS A FLEXIBLE SPENDING ACCOUNT (FSA)?

The FSA is available only to employees who elected the Your Blue $500 health plan option or elected to waive medical coverage. A Flexible Spending Account allows you to pay for qualified medical, dental and vision expenses with pre-tax dollars. However, these FSA dollars do not roll over from year to year or from one employer to another; any unused portion at the end of the year will be forfeited (except $660 for the Health Care FSA that can be carried over to the next year). All expenses must occur within the plan year: the cut-off is December 31, 2025.

With a Health Flexible Spending Account, your expenses are deducted from your paycheck pre-tax; before state, federal and social security taxes. By paying these expenses with pre-tax dollars, you will reduce your taxable income and take home a larger portion of your paycheck. You will need to use your FSA debit card or submit claims and copies of your receipts to receive reimbursement.

PLAN CAREFULLY!

- Annual contribution amounts you elect for the plan year must be set during enrollment and can not be changed except for a qualifying life event.
- Expenses must be incurred during the plan year – "use it or lose it!"
- Except $660 that can be carried over with the Health Care FSA.
- You must submit your claims by March 31st of the following year.

2025 MAXIMUM FSA CONTRIBUTIONS

The maximum yearly election amount for the Health Care FSA for 2025 is:

- $3,300

Contributions are made by employees only. Election amounts cannot be changed outside open enrollment without a qualifying life event.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

A Dependent Care Flexible Spending Account allows you to set aside pre-tax money to cover the cost of dependent care for children under age 13. You can elect this plan regardless of your medical plan selection.

Eligible care:

- Dependent day care
- Educational institution
- Home day care (provider cannot be your tax dependent)

The maximum yearly election amount for the Dependent Care FSA for 2025 is $2,500 per year if filing separately or $5,000 per year if you file your taxes as married filing jointly.

GLP-1 ALTERNATIVES

GLP-1 ALTERNATIVE

Alternative No to Low-Cost Benefit for GLP-1 Medications for Improved Clinical Efficiency in:

- Glucose Regulation and Insulin Control
- Metabolism and Appetite for Weight Management
- Cellular signaling for Gut-Brain Health

COST:

$0 Copay 90- Day Supply for Diabetic Weight Management
$250 Copay 90- Day Supply Anti-Obesity PPO Plan
$750 Copay 90- Day Supply Anti-Obesity HDHP-HSA Plan

INCLUDES:

Telehealth Assessment for GLP-1 Medication Qualification
Professional Obesity Counseling
Dietician Nutrition Counseling
90-Day Medication Supply

SEMAGLUTIDE*

Take better control of your insulin and weight today with Semaglutide. Named Ozempic* in the Diabetic Class and Wegovy* in the Weight Loss Class. Medallus will screen for qualifying markers and assist you in getting started which includes introduction to optional Registered Dietitians for lifestyle and behavior management programs.

TIRZEPATIDE*

Take better control of your insulin and weight today with Tirzepatide. Named Mounjaro* in the Diabetic Class and Zepbound* in the Weight Loss Class. Tirzepatide's dual agonism of GLP-1 and GIP offers a comprehensive approach to glucose control and weight loss.

CONTACT MEDALLUS
GLP-1patientcare@medallusmedicalnd.com
701-368-4380

SCAN THE QR CODE TO CONTACT US TO SEE IF YOU QUALIFY!

LIFE INSURANCE

BASIC LIFE INSURANCE

Dickinson Public Schools provides Basis Life and Accidental Death & Dismemberment Insurance for all eligible employees working 20 or more hours each week on a regular and continuous basis. Eligible employees receive a benefit of $50,000 as well as additional Accidental Death & Dismemberment of the matching amount if the death results from an accident or dismemberment. This insurance is administered through The Hartford.

Basic Life

Employee	$50,000
Monthly Premium	100% Employer Paid

VOLUNTARY LIFE INSURANCE

In addition to the coverage provided by the School District, you may purchase extra life insurance in the amount of $50,000 as well as additional Accidental Death & Dismemberment of matching amount if the death results from an accident or dismemberment.

Voluntary Life

Employee	$50,000
Yearly Premium for Life Insurance and AD&D	$117 annually, payroll deducted

KEEP YOUR BENEFICIARIES UP TO DATE

You must designate a beneficiary (the person who will receive the benefit) for your life and AD&D insurance when going through enrollment in Employee Navigator. Make sure to keep this person's information updated so your benefit is paid according to your wishes.

CONTACT INFORMATION
The Hartford
800-523-2233

THE HARTFORD

DISABILITY INSURANCE

LONG TERM DISABILITY

If you experience a disabling illness or injury that lasts longer than your STD benefit, LTD insurance can replace a percentage of your lost income after you have been unable to work for 90 days.

Dickinson Public Schools will provide long-term disability insurance for all licensed employees and classified employees who are employed for 20+ hours per week.

Benefits begin after 90 non-working calendar days and all PTO has been exhausted. To qualify for a disability an employee must be unable to engage in all the material duties of regular occupation, as certified by a licensed physician, for the first three years of disability. After three years, re-training for other occupations may be required.

CONTACT INFORMATION
The Standard
701-483-9104
www.standard.com

VOLUNTARY SHORT TERM DISABILITY

This voluntary coverage is a cost-effective way to protect your income when you are unable to work due to an illness or injury. Having short-term disability protection can help you cover your essential living expenses and help safeguard your savings, since it replaces a portion of your income during the initial weeks of disability.

For disability caused by accidental injury, physical disease, pregnancy or mental disorder, benefits begin after an elimination period of 14 days and cover 60% of your pre-disability salary up to weekly maximum of $2,000. Please refer to the policy if other circumstances apply. Short-Term Disability benefit duration is 11 weeks.

Extended Benefit Waiting Period –
This applies if you do not apply for this coverage within 31 days of becoming eligible, were eligible for coverage under a prior plan for more than 31 days but were not insured, or if your insurance ends because you failed to pay your premium and later reinstated.
60 days for any qualifying disability caused by physical disease, pregnancy or mental disorder occurring during the first 12 months of coverage.

STD Premiums by Age
(per $10 of covered weekly benefit)

Up to 29	$0.989
30-34	$1.024
35-39	$0.530
40-44	$0.282
45-49	$0.266
50-54	$0.277
55-59	$0.352
60+	$0.448

Example: You are 35 years old and your weekly pre-disability income is $1,400.

- STD benefit amount is $840
- $840 / $10 = $84 * $0.530 = $44.52
- Your monthly Voluntary STD premium is $44.52

EMPLOYEE ASSISTANCE PROGRAM (EAP)

SUPPORT FOR EVERYDAY ISSUES, EVERY DAY

The Employee Assistance Program (EAP) through SupportLinc offers expert guidance to help address and resolve everyday issues for all employees.

IN-THE-MOMENT SUPPORT

Reach a licensed clinician by phone 24/7/365 for immediate assistance.

SHORT-TERM COUNSELING

Access in-person or video counseling sessions to resolve concerns such as stress, anxiety, depression, relationship issues, work-related pressures, or substance abuse.

FINANCIAL EXPERTISE

Planning and consultation with a licensed financial counselor.

CONVENIENCE RESOURCES

Referrals for child and elder care, home repair, housing needs, education, pet care and so much more.

LEGAL CONSULTATION

By phone or in-person with a local attorney.

CONFIDENTIALITY

SupportLinc ensures no one will know you have accessed the program without your written permission except as required by law.

WEB PORTAL AND MOBILE APP

- The one-stop shop for program services, information and more.
- Discover on-demand training to boost wellbeing and life balance.
- Find search engines, financial calculators and career resources.
- Explore thousands of articles, tip sheets, self-assessments and videos.

CONVENIENT, ON-THE-GO SUPPORT

- **Textcoach®**
  Personalized coaching with a licensed counselor on mobile or desktop
- **Animo**
  Self-guided resources to improve focus, wellbeing and emotional fitness
- **Virtual Support Connect**
  Moderated group therapy sessions on an anonymous, chat-based platform

CONTACT INFORMATION
Phone: 1-888-881-5462
Web: supportlinc.com (dickinson)
Download the mobile app in the app store today!

supportlinc EMPLOYEE ASSISTANCE

AFLAC VOLUNTARY WORKSITE PLANS

GROUP ACCIDENT

Accidents can happen in an instant affecting you or a loved one. Aflac is designed to help families plan for health care bumps ahead and take some of the uncertainty and financial insecurity out of getting better.

PROTECTION FOR THE UNEXPECTED, THAT'S THE BENEFIT OF THE AFLAC GROUP ACCIDENT PLAN

After an accident, you may have expenses you've never thought about. Can your finances handle them? It's reassuring to know that an accident insurance plan can be there for you in your time of need to help cover expenses such as:

- Ambulance rides
- Emergency room visits
- Surgery and anesthesia
- Prescriptions
- Major diagnostic testing
- Burns

PLAN FEATURES

- Benefits are paid directly to you, unless otherwise assigned
- Coverage is guaranteed-issue (which means you may qualify for coverage without having to answer health questions)
- Benefits are paid regardless of any other medical insurance

Initial Treatment

Hospital Emergency Room/Urgent Care Facility - with Xray	$225
Hospital Emergency Room/Urgent Care Facility - without Xray	$175
Doctor's Office - with Xray/without Xray	$150/$100
Ambulance Ground/Air	$400/$1,200
Major Diagnostic Testing	$200
Concussion	$500
Coma	$7,500
Emergency Dental Work	$50-$200
Eye Injuries	$250
Burns	Up to $15,000
Fractures	Up to $3,000
Dislocations	Up to $2,500

Other benefits include, but not limited to, surgery and anesthesia, lacerations, transportation, appliances, therapy, hospital confinement, family member lodging, and more. Please refer to the Aflac benefit summary for a full list of coverage and limitations.

TO REGISTER FOR MYAFLAC:

1. Go to aflac.com/mypolicy
2. Click Register
3. Enter a policy number & click Submit
4. Complete the registration form & click Submit
5. Verify your email address
6. Click Agree to user agreement
7. Direct deposit enrollment: top right corner
   My Account>Manage Account>Payments and Deposits

CONTACT INFORMATION

Phone: 1-800-433-3036
Hours of Operation: Monday through Friday, 8am-8pm EST
To submit a claim, visit
www.aflacgroupinsurance.com

Local Agent: Morgan Meyer
Phone: 701-321-1272
morgan_meyer@us.aflac.com

GROUP CRITICAL ILLNESS

Aflac can help ease the financial stress of surviving a critical illness

Chances are you may know someone who's been diagnosed with a critical illness. You can't help but notice the difference in the person's life - both physically and emotionally. What's not so obvious is the impact a critical illness may have on someone's personal finances.

That's because while a major medical plan may pay for a good portion of the costs associated with a critical illness, there are a lot of expenses that may not be covered. And, during recovery, having to worry about out-of-pocket expenses is the last thing anyone needs.

That's the benefit of an Aflac Group Critical Illness Plan. It can help with the treatment costs of covered critical illnesses, such as heart attack or stroke. Most importantly, the plan helps you focus on recuperation instead of the distraction of out-of-pocket costs. With the Critical Illness plan, you receive cash benefits directly (unless otherwise assigned) - giving you the flexibility to help pay bills related to treatment or to help with everyday living expenses.

Covered Critical Illnesses

Cancer (internal or invasive)	100%
Heart Attack (Myocardial Infraction)	100%
Stroke (Ischemic or Hemorrhagic)	100%
Kidney Failure (End-Stage Renal Failure)	100%
Bone Marrow Transplant (Stem Cell Transplant)	100%
Sudden Cardiac Arrest	$500
Major Organ Transplant (25% of this benefit is payable for insureds placed on a transplant list for a major organ transplant)	100%
Non-Invasive Cancer	25%
Coronary Artery Bypass Surgery	2%

HEALTH SCREENING BENEFIT
$50 PER CALENDAR YEAR

The health screening benefit is payable once per calendar year for health screening tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations. This benefit payable for each insured.

GROUP HOSPITAL CONFINEMENT

The plan that can help with expenses and protect your savings

Does your major medical insurance cover all your bills? Even a minor trip to the hospital can present you with unexpected expenses and medical bills. And even with major medical insurance, your plan may only pay a portion of your entire stay.

That's how the Aflac Group Hospital Indemnity plan can help. It provides financial assistance to enhance your current coverage. It may help avoid dipping into savings or having to borrow to address out-of-pocket expenses major medical insurance was never intended to cover. Like transportation and meals for family members, help with child care, or time away from work, for instance.

Benefits Include

Hospital Admission Benefit	$1,000 per confinement
Hospital Confinement	$150 per day
Hospital Intensive Care	$150 per day

Additional benefits include successor insured benefit, inpatient surgery and anesthesia, outpatient surgery and anesthesia, facilities fee, and health screening benefit.

For more information on all of these plans as well as limitations, please refer to the official Aflac Benefit Brochures or the contact Aflac using the information on the previous page.

BENEFITS MOBILE APP

YOUR BENEFITS | ANYTIME, ANYWHERE

WHAT INFORMATION CAN EMPLOYEES ACCESS ON THE APP?

- Download and print benefit related documents and forms
- Quickly find service contact information and online resources
- Review benefit plan design information
- Find online provider directories

WILL THE MOBILE APP WORK ON MY DEVICE?

Yes, the app is what's known as a "web app", which means there is nothing to download, no need to access an "app store", etc... it's ready for use when employees access the site address from their device.

ADD TO HOME SCREEN

Employees can simply type the web address listed on the right into their phones internet browser and follow the instructions below.

GO TO

dickinson.mybenefitsapp.com

SCAN ME!

Add the icon to your smartphone for quick access!

iPhone	Android	Windows Phone
Tap the Share Icon in Safari's lower menu bar	Tap this Icon in the top right menu bar	Tap this Icon in the lower right corner
Tap the "**Add to Home Screen**" icon	Select: "**Add to Home Screen**"	Select: "**Pin to Start**"

CONTACT INFORMATION

MEDICAL

BlueCross BlueShield ND
844-363-8457
www.bcbsnd.com

DENTAL

Companion Life
877-676-5789
www.companionlife.com

VISION

Unum
888-400-9304
www.unumvisioncare.com

HSA/FSA/DCFSA

Wex, Inc.
866-451-3399
www.wexinc.com/login

TELEHEALTH

Amwell
855-818-3687
www.patients.amwell.com

DISABILITY

The Standard
701-483-9104
www.standard.com

LIFE INSURANCE

The Hartford
1-800-523-2233
www.thehartford.com

VOL. WORKSITE PLANS

Aflac
800-433-3036
www.aflacgroupinsurance.com
Morgan Meyer: 701-321-1272 or
morgan_meyer@us.aflac.com

EMPLOYEE ASSISTANCE PROGRAM

SupportLinc
1-888-881-5462
www.supportlinc.com

IMPORTANT NOTICES

IMPORTANT NOTICE 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 Dickinson 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:

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you 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.

Dickinson has determined that the prescription drug coverage offered by the Insurance plan is, on average for all plan Employees, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. You may also enroll from October 15th through December 7th in 2023. If you enroll from October 15th through December 7th in 2023, your coverage will begin on January 1, 2024.

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.

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 Dickinson and don't join a Medicare drug plan within 63 continuous days aft er 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 the coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

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

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Dickinson 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 Medicare Part D 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).

What happens to your current coverage if you decide to join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

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

HIPAA SPECIAL ENROLLMENT NOTICE

NOTICE OF SPECIAL ENROLLMENT RIGHTS FOR MEDICAL PLAN COVERAGE

As you know, if you have declined enrollment in Dickinson' health plan for you or your dependents (including your spouse/domestic partner) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under this plan without waiting for the next open enrollment period, provided that you request enrollment within 30 days aft er your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Dickinson will also allow a special enrollment opportunity if you or your eligible dependents either:

+ Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
+ Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days – instead of 30 – from the date of the Medicaid/CHIP eligibility change to request enrollment in Dickinson group health plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another medical plan. Any other currently covered dependents may also switch to the new plan in which you enroll.

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 this plan. Please see the Plan's Summary Plan Description for details of the Plan's deductible, benefit percentage, and copayment requirements. If you would like more information on WHCRA benefits, contact HR.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

CONTINUATION COVERAGE RIGHTS UNDER COBRA

You are receiving this notice because you have recently become covered under Dickinson group health plan. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to you when you would otherwise lose your group health coverage. It can also become available to other Employees of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact HR.

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

If you are the spouse/domestic partner of an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

+ Your spouse/domestic partner dies; Your spouse/domestic partner's hours of employment are reduced;
+ Your spouse/domestic partner's employment ends for any reason other than his or her gross misconduct;
+ Your spouse/domestic partner becomes enrolled in

Medicare benefits (under Part A, Part B, or both); or

+ You become divorced or legally separated from your spouse/domestic partner.

If the Plan provides health care coverage to retired Employees, the following applies: filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired Employee covered under the Plan, the retired Employee will become a qualified beneficiary with respect to the bankruptcy. The retired Employee's spouse/domestic partner, surviving spouse/domestic partner, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after Dickinson has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, in the event of retired Employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify Dickinson of the qualifying event.

REQUIRED NOTICE

You must give notice of some qualifying events for the other qualifying events (divorce or legal separation of the Employee and spouse/domestic partner or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days aft er the qualifying event occurs. Contact your employer and/ or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

HOW IS COBRA COVERAGE PROVIDED?

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitle to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries, other than the Employee, lasts until 36 months aft er the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse/domestic partner and children can last up to 36 months aft er the date of Medicare entitlement, which is equal to 28 months aft er the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify Dickinson in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact Dickinson and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

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

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to Dickinson. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep Dickinson informed of any address changes. You should also keep a copy, for your records, of any notices you send to Dickinson.

PLAN CONTACT INFORMATION

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

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

NORTH DAKOTA – Medicaid

Website: https://www.hhs.nd.gov/healthcare

Phone: 1-844-854-4825

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

U.S. Department of Labor Employee Benefits Security Administration

www.dol.gov/agencies/ebsa | 1-866-444-EBSA (3272)

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services

www.cms.hhs.gov | 1-877-267-2323, Menu Option 4, Ext. 61565

Paper Reduction Act Statement

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

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137. OMB Control Number 1210-0137 (expires 1/31/2026).

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: General Information

Form Approved OMB No. 1210-0149 (expires 12-31-2026)

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

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer

that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[12]

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

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

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

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

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

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

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your Summary Plan Description or contact: BCBSND at 844-363-8457.

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.

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.

Employer name: Dickinson

Employer Identification Number: 45-60001585

Employer phone number: 701-456-0002

Employer address: 444 4th street West, Dickinson, ND 58601

Contact about coverage: Meghan Teske, HR Manager

Phone number: 701-456-0002

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

As your employer, we offer a health plan to: Some employees. Eligible employees are full-time employees and employees who work an average of 30 hours per week.

With respect to dependents: We do offer coverage. Eligible dependents are spouses/domestic partners and children.

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

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

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

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

NOTICE OF AVAILABILITY OF HIPAA PRIVACY NOTICE

Under the Health Insurance Portability and Accountability Act (HIPAA) health plans are required to provide covered individuals with a Privacy Notice that describes, among other things, the uses and disclosures of protected health information that may be received by the plans, your rights regarding that information and the plan's responsibilities.

HIPAA requires that at this time we advise you that a copy of the Privacy Notice is available by:

+ Contacting Human Resources and requesting a hard copy

Please contact us for more information:

Dickinson Human Resources:

meghanteske@dpsnd.org

701-456-0002

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services Office for Civil Rights

200 Independence Avenue, S.W.

Washington, D.C. 20201

202-619-0257

Toll Free: 877-696-6775

THANK YOU!

This Guide is intended to describe the eligibility requirements, enrollment procedures, and coverage effective dates for the benefits offered by Dickinson Public Schools. This Guide is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. This Guide is a tool to answer most of your questions. Full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each Plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

This guide is designed and provided by:

Brown & Brown