



Leech Lake Band  
of Ojibwe



2021

# Benefits Guide

Your Benefits, Your Choice

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## WELCOME TO YOUR EMPLOYEE BENEFITS!

We understand that your life extends beyond the workplace. That is why we offer a variety of benefit plans to help you and your family. We provide health and financial security options so you can focus on being the best at what you do and enjoy your life.

Within this guide, you will find the highlights of each of the benefits including Medical, Dental, Vision, Life, Disability, Critical Illness, Accident Insurance, and more!

LLBO is a Self-Funded Plan, funded by the employee and employer. LLBO subsidizes a portion of your insurance premiums to provide a quality and affordable health plan to you. We strive to provide you and your family with a comprehensive and valuable benefits package and we want to make sure you are getting the most of our benefits – that is why we have put together this Open Enrollment Guide.

Open enrollment is a short period each year when you can make changes to your benefits. This guide will outline all of the different benefits offered by the Band, so you can identify which offerings are best for you and your family.

### Current Employees

If you take no action during your open enrollment period, your current benefit elections will roll over. Once Open Enrollment ends, you will not have another opportunity to make changes until next year unless you experience a qualifying life event like a birth, adoption, marriage, or divorce before that time.

### New Employees

This is your chance to elect benefits and enroll yourself and your eligible dependents. Some benefits have “guarantee issue” at your first opportunity only, so please carefully consider this before you decline any coverages. If you take no action now, you will have no benefits and you will not have another chance to elect them until next year’s open enrollment - unless you experience a qualifying life event like a birth, adoption, marriage, or divorce before that time.

If you have questions about any of the benefits mentioned in this guide, please do not hesitate to reach out to HR.

# IMPORTANT CONTACT INFORMATION

## Benefit Contact Information

Coverage	Carrier	Phone Number	Website
Medical Insurance	BlueLink TPA	1-833-803-4457	<a href="http://www.myQCCbluelink.com">www.myQCCbluelink.com</a>
Prescription Drug Coverage	ClearScript Rx	1-855-816-6389	<a href="http://www.clearscript.org">www.clearscript.org</a>
Prescription Drug Coverage Prior Auth	ClearScript Rx	1-877-355-0321	<a href="http://www.clearscript.org">www.clearscript.org</a>
Dental Insurance	Delta Dental	1-800-553-9536	<a href="http://www.deltadentalmn.org">www.deltadentalmn.org</a>
Long-Term Disability Income	Unum	1-800-421-0344	<a href="http://services.unum.com">services.unum.com</a>
Critical Illness, Accident	Unum	1-800-635-5597	<a href="http://services.unum.com">services.unum.com</a>
Basic Life, AD&D, Supplemental Life & Voluntary AD&D Insurance and Short-Term Disability	The Hartford	1-800-421-0344	<a href="http://www.thehartford.com">www.thehartford.com</a>
401(k)	Ascensus	1-866-809-8146	<a href="https://www.planservices.com/rplink">https://www.planservices.com/rplink</a>

## Human Resources Contact Information

HR Contact	Position	Phone Number	Email
Joy Lawrence	LLBO	218-335-8200	<a href="mailto:Joy.Lawrence@llojibwe.org">Joy.Lawrence@llojibwe.org</a>
Devery Staples	LLBO	218-335-4467	<a href="mailto:devery.staples@llojibwe.net">devery.staples@llojibwe.net</a>
Melissa Mcfarlane	Tribal College	218-335-4200	<a href="mailto:melissa.mcfarlane@lrtc.edu">melissa.mcfarlane@lrtc.edu</a>
Gina Fairbanks	Leech Lake Housing Authority	218-335-4414	<a href="mailto:gcampbell@midconetwork.com">gcampbell@midconetwork.com</a>



**DISCLAIMER:** The information described within this guide is only intended to be a summary of your benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description for a complete explanation of your benefits. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail. You can obtain a copy of the Summary Plan Description from the Human Resources Department.



# ELIGIBILITY, ENROLLMENT & CHANGES

## Employee Eligibility

As a new employee, you have 30 days from your initial start date to enroll in benefits if you are in one of the following Employee Groups working the required amount of hours:

### Class IV: Department of Public Safety and Resource Management Employees

- **Eligibility:** Full-time employees working a minimum of 30 hours per week.
- **Effective:** First of the month following the date full-time employment begins.
- **Eligibility:** Basic Life and Short-Term Disability- Full-time employees working a minimum of 35 hours per week.
- **Effective:** First of the month coinciding with or following date of hire.

### Class III: Government and Housing Division Employees

- **Eligibility:** Full-time employees working a minimum of 30 hours per week.
- **Effective:** First of the month following completion of the 60-day waiting period.
- **Eligibility:** Basic Life and Short-Term Disability- Full-time employees working a minimum of 35 hours per week.
- **Effective:** First of the month following 6 months from date of hire.

### Class I: Bug-o-nay-ge-shig, Head Start Program or Heritage Site Program Employees

- **Eligibility:** Medical- Full-time employees working a minimum of 30 hours per week.
- **Effective:** First day of the school year if working full-time on that date, or the first of the month following the date full-time employment begins.
- **Eligibility:** Basic Life and Short-Term Disability- Full-time employees working a minimum of 37 hours per week.
- **Effective:** First day of the school year if working full-time on that date, or the first of the month following the date full-time employment begins.

### Class II: Tribal College Employees

- **Eligibility:** A faculty member who is regularly scheduled to teach a minimum of eight credits per week per quarter; or administrative staff scheduled to work a minimum of 30 hours per week.
- **Effective:** First of the month following completion of the 60-day waiting period.

- **Eligibility:** Basic Life and Short-Term Disability- Full-time faculty member teaching a minimum of 8 credits per week per quarter.
- **Effective:** First of the month coinciding with of following 6 months of employment.

## Dependent Spouse Eligibility

The Employee's legally married Spouse or same sex Domestic Partner.

## Dependent Child(ren) Eligibility

The Employee's dependent children at the end of the month, in which, they attain age 26, legally adopted children from the date the Employee assumes legal responsibility, foster children that live with the Employee and for whom the Employee is the primary source of financial support, children for whom the Employee assumes legal guardianship and stepchildren. Also included are the Employee's children (or children of the Employee's Spouse) for whom the Employee has legal responsibility resulting from a valid court decree.

Children who are mentally or physically disabled and totally dependent on the Employee for support, past the age of 26 or older. To be eligible for continued coverage past the age of 26, certification of the disability is required within 31 days of attainment of age 26. A certification form is available from the Employer or from the Claims Administrator and may be required periodically. You must notify the Claims Administrator and/or the Employer if the Dependent's marital or tax exemption status changes and they are no longer eligible for continued coverage.

## Qualifying Life Event Changes

Changes in the Employee's legal marital status such as marriage, divorce, or the death of a spouse. A change in the number of dependents such as birth, death, or adoption. A dependent becomes eligible or ceases to be eligible for coverage due to age. An election change must be made within 30 days of the qualifying event.

## Pre-Tax Election Notice

Employee premiums will be deducted on a pre-tax basis through payroll deduction, unless otherwise requested by the employee. Due to IRS rules, elections cannot be revoked or changed during the plan year, unless you experience a qualifying event or "Status Change" as described herein.

# EMPLOYEE CONTRIBUTIONS

Below is an overview of your associate contributions for 2021. These are subject to change. If you have questions or concerns, please speak with Human Resources.

Medical Insurance	Per Paycheck	
<b>PPO \$400 Plan</b>	With Wellness Incentive	Without Wellness Incentive
Employee Only	\$66.21	\$79.45
Family	\$190.48	\$228.58
<b>\$6,350 HDHP with HSA</b>		
Employee Only	\$47.10	
Family	\$135.41	

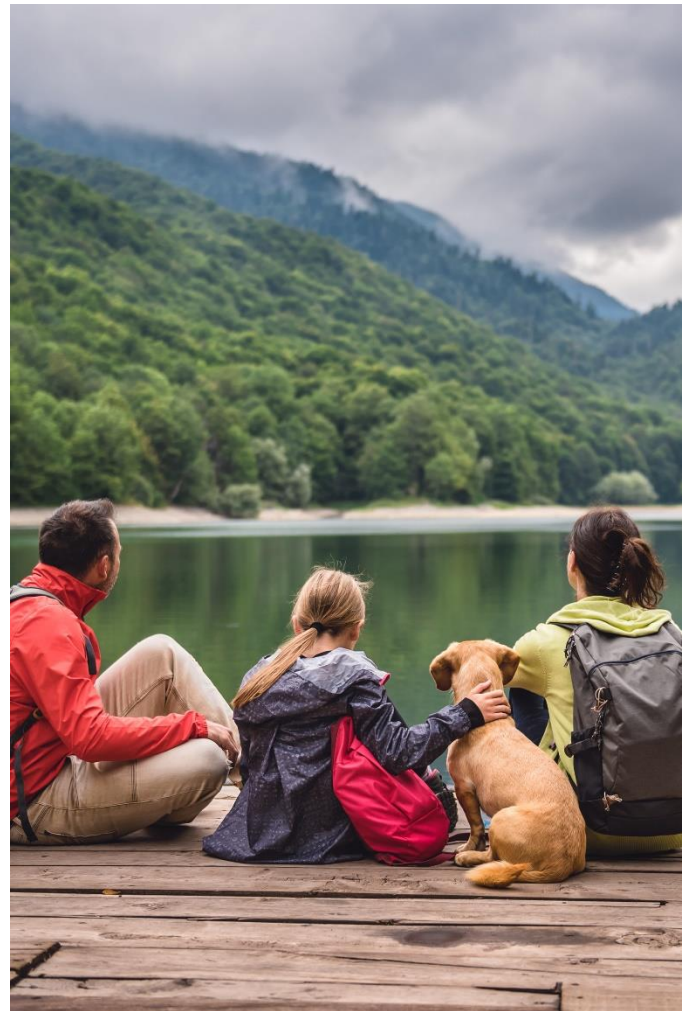
## \$400 Deductible Plan

This is a Traditional Health Plan with a Deductible of \$400 and co-pays for Prescription Drugs and Emergency Room visits. Members pay the first \$400 individual or \$1,000 family coverage for services such as Physician visits and in or out patient hospital services.

## \$6,350 High Deductible Health Plan (HSA Eligible)

This is a High Deductible Health Plan (HDHP) that is HSA qualified. Members pay the first \$6,350 individual or \$12,700 family coverage for all services. Once the deductible has been met, all eligible services are covered at 100% for that plan year.

Dental Insurance	Per Paycheck
Employee Only	\$4.25
Family	\$11.73



# MEDICAL INSURANCE

## BlueLink TPA

The Band provides associates the option to purchase affordable medical coverage. This plan allows you to visit any doctor or facility you choose – however, you will get the best coverage when you choose an in-network provider.

For a complete list of your in-network and out-of-network benefits, please refer to your Medical Insurance Summary Plan Description, provided by Human Resources.



Medical Plan Details	BlueLink TPA \$400 Deductible Plan	BlueLink TPA \$6,350 HDHP
<b>Calendar Year Deductible</b>		
Individual	\$400	\$6,350
Family	\$1,000	\$12,700
<b>Coinsurance</b>		
Plan Pays	80%	100%
You Pay	20%	0%
<b>Annual Out-of-Pocket Max</b>		
Individual	\$2,000	\$6,350
Family	\$4,500	\$12,700
<b>Medical Coverage</b>	<b>In-Network</b>	<b>In-Network</b>
<b>Preventative Care</b>	No charge	No charge
<b>Primary Care Office Visit</b>	Deductible, then 20%	Deductible, then \$0
<b>Specialist Office Visit</b>	Deductible, then 20%	Deductible, then \$0
<b>Urgent Care</b>	Deductible, then 20%	Deductible, then \$0
<b>Emergency Room</b>	\$100 copay, then 20% after deductible	Deductible, then \$0
<b>Hospitalization</b>	Deductible, then 20%	Deductible, then \$0
<b>Rx Drug Coverage</b>		
<b>Tier 1</b>	\$10 copay	Deductible, then \$0
<b>Tier 2</b>	\$25 copay	Deductible, then \$0
<b>Tier 3</b>	\$35 copay	Deductible, then \$0
<b>Tier 4</b>	\$35 copay	Deductible, then \$0
<b>Vision Benefit</b>		
<b>Exam</b>	No Charge	N/A
<b>Eyeglasses</b>	Up to \$300 per calendar year	N/A
<b>Medical Insurance</b>		
<b>Benefit Cost</b>	See page 5.	



# WELLNESS PROGRAM

## HealthCheck360

Leech Lake Band of Ojibwe is pleased to offer you an exciting addition to your benefits package. LLBO offers all employees and spouses the opportunity to participate in **HealthCheck360** wellness program.

The wellness program will assist you in managing your current health and gaining awareness in areas that display possible risks.

### Wellness Program Includes

<b>Biometric Screening</b>	A screening given by a certified health professional which includes a series of measurements and a blood draw. The exam requires an eight hour fast before your scheduled appointment.
<b>Health Risk Assessment Survey</b>	A lifestyle survey that includes topics shown to be significant future health risks. The way you answer the survey questions has no affect on the score you receive.
<b>Health Report</b>	After the survey is complete, you will receive an individual report outlining your HealthCheck360 score (0-100) and an overview of your physical and emotional health. The score you receive is based solely on objective measurements from the biometric screening.
<b>Health Coaching Call</b>	A call with a HealthCheck360 Health Coach to review your biometric results, set attainable goals, and gain confidence in your ability to maintain good health.
<b>Wellness Portal</b>	<a href="http://myHealthCheck360.com">myHealthCheck360.com</a> , an online wellness portal provides nutrition and activity trackers, and the chance to participate in wellness challenges with coworkers.
<b>Confidentiality</b>	All information is confidential. Your personal results will not be shared with any representatives at LLBO.
<b>Program Cost</b>	100% paid by Leech Lake Band of Ojibwe



Participation in the HealthCheck360 screening can earn you a **20% reduction** in your health insurance premiums.

### Participation Incentives

In addition to offering the program at no charge, we will also provide incentives for participation and for improving your health over time.

### When Do Screenings Take Place?

The screenings will take place at a LLBO location near you, starting near the end of the summer. Information on how to schedule your screening appointment will be coming soon.

### Track Your Progress

All participants have their own personalized wellness portal and ongoing support from HealthCheck360 Health Coaches. The wellness portal provides:

- Nutrition and activity trackers
- Ability to sync your FitBit
- Opportunity to do individual challenges with coworkers and the chance to participate in Band wide wellness challenges.



# DENTAL INSURANCE

## Delta Dental

The Delta Dental PPO gives you access to a network of dentists that have agreed to a discount payment schedule. You are not required to designate a Primary Care Dentist, and you have the choice to select any participating Delta PPO or Premier dentist. You may choose to obtain services from a non-network provider; however, your out-of-pocket costs will be higher. To locate a participating dental care provider, go to [www.DeltaDentalMN.com](http://www.DeltaDentalMN.com).

For a complete list of your in-network and out-of-network benefits, please refer to your Dental Insurance Summary Plan Description, provided by Human Resources.

Dental Plan Details	Delta Dental PPO	Delta Dental Premier	Non-Participating
<b>Calendar Year Deductible</b>			
Individual	\$50/person	\$50/person	\$50/person
Family	\$150/family	\$150/family	\$150/family
<b>Annual Out-of-Pocket Max</b>	\$1,500	\$1,500	\$1,500
<b>Ortho Lifetime Max</b>			
Individual	\$1,500	\$1,500	\$1,500
Family			
Coverages	In-Network	Out-of-Network	Non-Participating
<b>Preventative Care</b>	100%	100%	100%
<b>Basic Services</b>	80%	80%	80%
<b>Major Services</b>	70%	70%	70%
<b>Orthodontia Services (Up to age 19)</b>	50%	50%	50%

Dental Insurance	Per Paycheck
Employee Only	\$4.25
Family	\$11.73



# BASIC LIFE & AD&D INSURANCE

## The Hartford

Leech Lake Band of Ojibwe wants you to be covered and your family to be protected, which is why we are offering all full-time eligible employees Band-Paid Life and Accidental Death & Dismemberment (AD&D) coverage through **The Hartford**. AD&D provides an additional benefit if you die or become dismembered due to a specifically covered accident

### Beneficiaries

Your designated beneficiary will receive a benefit to help ease their financial burden if you die. If you do not update your beneficiaries, it will make it harder for the right person to receive your benefit, if ever needed. Please update your beneficiaries periodically.

#### Basic Life/AD&D Insurance – Employee Coverage

<b>Coverage Amounts</b>	<b>Employees working 30* or more hours per week: \$30,000</b> *37 or more hours for Class I employees
<b>Reduction Schedule</b>	65% at age 65 and 50% at age 70
<b>Benefit Cost</b>	100% paid by Leech Lake Band of Ojibwe

#### Basic Life/AD&D Insurance – Dependent Coverage

<b>Coverage Amounts</b>	<b>Legal Spouse: \$5,000</b> <b>Minor Children: \$2,500</b>
<b>Benefit Cost</b>	\$1.11 deducted from first payday of each month

### Accidental Death & Dismemberment (AD&D)

AD&D pays a benefit for loss of life or dismemberment resulting from an accidental bodily injury. Your beneficiary will receive 100% of the AD&D amount if you die as the result of an accidental injury. You will receive an accidental dismemberment benefit if you lose a hand, a foot, or the sight of an eye due to an accidental injury. The benefit paid is 50% of the AD&D amount for any 1 loss and 100% of the AD&D amount for any 2 or more losses.

# VOLUNTARY LIFE/AD&D INSURANCE

## The Hartford

In addition to the Band-Paid life insurance benefit provided by Leech Lake Band of Ojibwe, you have the opportunity to purchase Voluntary Life and Accidental Death & Dismemberment (AD&D) coverage through **The Hartford**.

#### Voluntary Life/AD&D

<b>Coverage Amounts</b>	<b>Employee:</b> \$10,000 increments up to \$300,000 <b>Spouse:</b> \$5,000 increments to \$50,000 not to exceed 50% of Employee Amount <b>Dependent Child(ren):</b> Up to \$10,000 depending on your child's age
<b>Guarantee Issue Amounts</b>	<b>Employee:</b> \$100,000 <b>Spouse:</b> \$50,000 <b>Children:</b> 10,000
<b>Reduction Schedule</b>	65% at age 65 and 50% at age 70

Age	<30	30-34	35-39
<b>Rate per \$100</b>	\$0.06	\$0.07	\$0.09

Age	40-44	45-49	50-54
<b>Rate per \$100</b>	\$0.14	\$0.23	\$0.36

Age	55-59	60-64	65-69
<b>Rate per \$100</b>	\$0.57	\$0.90	\$14.41

Age	70+	Child Life Rate
<b>Rate per \$100</b>	\$2.88	\$0.20 per \$1,000

Please review the full summary plan documents for a list of your exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. Please refer to your certificate booklet for your complete plan description. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

# SHORT-TERM DISABILITY

## The Hartford

In the event you are unable to work as a result of an illness or injury, Leech Lake Band of Ojibwe provides disability insurance through **The Hartford**. The plans offer income protection and will replace a portion of your earnings while you are unable to work.

### Voluntary Short-Term Disability Insurance

<b>Elimination Period</b>	Zero (0) days – Injury Seven (7) days – Sickness
<b>Benefit Percentage</b>	67%
<b>Maximum Weekly Benefit</b>	Up to \$450 per week
<b>Maximum Period of Payment</b>	26 weeks
<b>Definition of Earnings</b>	Date of pay immediately prior to the date of disability
<b>Benefit Cost</b>	100% paid by Leech Lake Band of Ojibwe

### Eligibility

All full time regular employees are eligible the first of the month after the first **six (6) months** of employment and have averaged **35 hours or more of work per week** during that period.

### What Is Basic Weekly Compensation?

“**Basic Weekly Compensation**” means the basic weekly rate of pay of the employee prior to the date of disability. Basic Weekly Compensation does not include commissions, overtime pay, tips, bonuses or any other compensation not received as basic wages.

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### How do I submit a claim?

Hartford Life Insurance Company is the Third Party Administrator (TPA) for processing of all Short-Term Disability claims. To submit a claim, a Hartford Life Insurance Company “Application for Short-Term Disability Income Benefits” form must be completed and sent to the Benefits Department at Gaming. Forms can be obtained from the Admin Offices on site, or can be picked up at the Gaming office. Completed application forms can be mailed inter-office, USPS, dropped off at the Gaming office or faxed using the Benefits Department **secure fax, 218-335-7558**.

A “**Personnel Action Form**” (PAF) putting the employee on leave must be completed by their manager and sent to Wanda Bellanger. The Benefits staff will then complete the employer form and along with the employee Statement of Disability and physician forms will be faxed to Hartford Life Insurance Company for approval or denial.

All payments come directly from Hartford Life Insurance Company and are mailed to the address you put on the “Statement of Disability” form.

All Hartford Life Insurance Company Statements of Disability must have a medical diagnosis/description and **must be signed by a legally qualified physician**. All Short-Term Disability claims are subject to acceptance or denial by Hartford Life Insurance Company. This determination is not made by the Gaming Benefits staff.

# VOLUNTARY LONG-TERM DISABILITY

## Unum

Long-Term Disability Insurance is available for employees to purchase on a voluntary basis.

Long-Term Disability Insurance	
<b>Elimination Period</b>	180 days or the date your Short-Term Disability payments end
<b>Benefit Percentage</b>	60%
<b>Maximum Monthly Benefit</b>	\$5,000
<b>Pre-existing Conditions Limitation</b>	12/12/24 Pre-existing condition means any sickness or injury for which you have received medical treatment, consultation, care or services during the 12 months prior to the coverage effective date. A disability arising from any such sickness or injury will be covered only if it begins after you have performed your regular occupation on a full-time basis for 24 months following the coverage effective date, unless no treatment was received for 12 consecutive months after the coverage effective date.
<b>Maximum Benefit Period</b>	If under age 60. If over the age of 60, see Summary Plan Description for details.
<b>Additional Features</b>	Employee Assistance Program



Age	<24	25-29	30-34
<b>Rate per \$100 of covered payroll</b>	\$0.210	\$0.290	\$0.400

Age	35-39	40-44	45-49
<b>Rate per \$100 of covered payroll</b>	\$0.520	\$0.620	\$0.800

Age	50-54	55-59	60-64
<b>Rate per \$100 of covered payroll</b>	\$1.030	\$1.130	\$1.200

Age	65-69	70-99	
<b>Rate per \$100 of covered payroll</b>	\$1.500	\$1.860	

### Employee Assistance Program (EAP)

This voluntary benefit also comes with an Employee Assistance Program (EAP). Work-life balance provides professional assistance for a wide range of personal and work-related issues. The service is available to you and your family members 24 hours a day, 365 days a year, and provides resources to help employees find solutions to everyday issues, such as financial a car or selecting child care, as well as more serious problems, such as alcohol or drug addiction, divorce or relationship problems. There is no charge for using the program.

**Please review the full summary plan documents for a list of your exclusions and limitations.** This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. Please refer to your certificate booklet for your complete plan description. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.



# ADDITIONAL VOLUNTARY BENEFITS

## Unum

You have the option to purchase additional voluntary benefits via post-tax payroll deductions through **Unum**. Benefits you may purchase include Critical Illness, Group Accident and Whole Life Insurance.

### Critical Illness Insurance

The Critical Illness plan is designed to help employees and their families with the out-of-pocket costs associated with a critical illness.

#### Critical illnesses include:

- Heart Attack
- Stroke
- Major Organ Transplant
- End-Stage Kidney Failure
- Coronary Artery Bypass Graft
- Cancer

Critical Illness Insurance	
<b>Benefit Amount</b>	<p><b>Employees:</b> \$5,000 to \$50,000, in \$1,000 increments</p> <p><b>Spouse:</b> \$5,000 to \$30,000, in \$1,000 increments</p> <p><b>Dependent Children:</b> \$2,500 to \$5,000</p>
<b>Payment</b>	Benefits are paid directly to the insured on a post-tax basis.
<b>Portability</b>	This plan is portable, so you may continue coverage if you leave the Band for any reason.
<b>Health Screening Benefit</b>	This benefit pays \$50 per calendar year, per insured individual, if a covered health-screening test is performed.
<b>Reduction Schedule</b>	Policy amount reduces 50% at age 70.
<b>Exclusions and Limitations</b>	No benefits will be paid for cancer or carcinoma in situ if the date of diagnoses occurs during the first 30 days of the effective date.
<b>Benefit Cost</b>	Please see Human Resources Representative for rates.

### Accident Insurance

The Accident plan is designed to help employees and their families with the out-of-pocket costs associated with an accident. This coverage pays a lump sum benefit based on the type of injury you sustain or the type of treatment you need.

#### Examples of covered injuries and expenses include:

- Broken bones
- Burns
- Torn ligaments
- Concussion
- Eye injuries
- Ruptured discs
- Cuts repaired by stitches
- Fractures
- Emergency Room treatment
- Hospitalization
- Physical Therapy

Accident Insurance	
<b>Eligibility</b>	Coverage is available to actively at work Employees, spouses ages 17-80 if not disabled and Children ages 14 days through 24 years old who are not disabled and/or married.
<b>Hospital Sickness Confinement Rider</b>	You have the option to add a Hospital Sickness Confinement Rider, which would pay if in the hospital for a covered illness.
<b>Guarantee Issue</b>	Coverage is Guarantee Issue, no medical questions are asked.
<b>Portability</b>	The plan is portable, so you may continue coverage if you leave the Band.
<b>Benefit Cost</b>	Please see Human Resources Representative for rates.

Please review the full summary plan documents for a list of your exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. Please refer to your certificate booklet for your complete plan description. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

# ADDITIONAL VOLUNTARY BENEFITS (CONT.)

## Unum

### Group Hospital Indemnity Insurance

Hospital Indemnity Insurance pays benefits to help employees and their families meet the costs of a covered hospital stay.

Group Hospital Indemnity Insurance	
<b>Hospital Admission</b>	\$1,500 for each covered hospital admission (once per calendar year)
<b>Hospital Stay</b>	\$100 for each day of your covered hospital stay, up to 60 days per calendar year
<b>Hospital Intensive Care Unit (ICU) Confinement</b>	\$200 for each day of covered hospital intensive care unit confinement, up to 15 days per calendar year
<b>Emergency Room Treatment*</b>	\$150 per insured per calendar year
<b>Ambulance Transport*</b>	\$100 per trip, once per calendar year
<b>Air Ambulance Transport*</b>	\$500 per trip, once per calendar year
<b>Benefit Cost</b>	Please see Human Resources Representative for rates.

\*Accident only.

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### Whole Life Insurance

Whole Life Insurance offers “living benefits” you can use when you need them, as well as a death benefit.

Whole Life Insurance	
<b>Level for Life</b>	Your premiums are level for life. Your death benefit is level for life also.
<b>Portability</b>	You own the policy. If you leave the Band or retire, you’ll pay the same premium.
<b>Benefit Cost</b>	Rates vary based on age, coverage amount and tobacco use. Please see your HR Representative for details.

# IN-NETWORK VS OUT-OF-NETWORK

## The Basics

Knowing the difference between an in-network and out-of-network provider can save you a lot of money.

- **In-network Provider**—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.
- **Out-of-network Provider**—A provider who is not contracted with your health insurance company.

## Getting the Most Out of Your Care

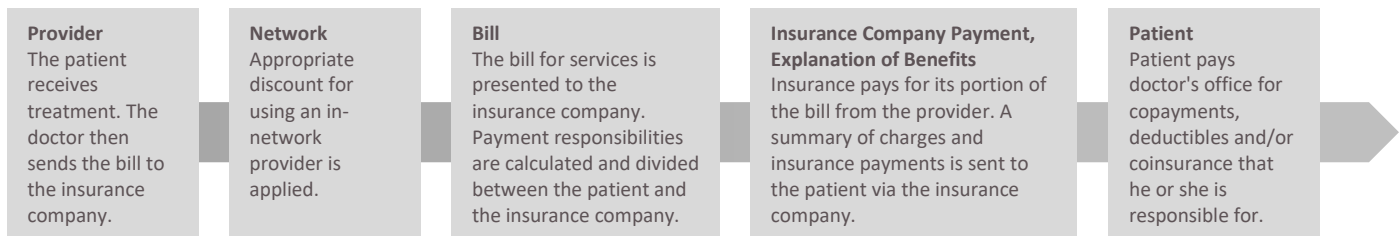
Calling the physician directly and double-checking with your insurance company is the best way to ensure that the provider is in-network.

If you are receiving surgery, make sure to ask if the service is completely in-network. Often times, things such as anesthesia are not covered even though the primary physician is in-network.

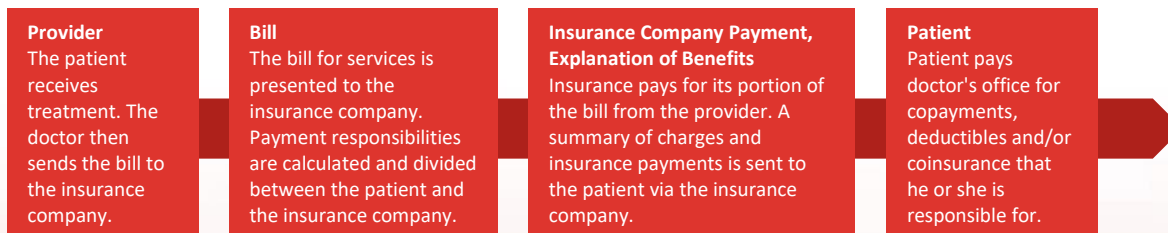
## Billing & Claim Differences

Because in-network and out-of-network providers are treated differently by your health insurance company, you will be billed differently depending on the type of provider you use for your care.

### In-Network Bill



### Out-of-Network Bill



## Preventive Care

Preventive care is a type of health care whose purpose is to shift the focus of health care from treating sickness to maintaining wellness and good health. This includes a variety of health care services, such as a physical examination, screenings, laboratory tests, counseling and immunizations.

Preventive care also helps lower the long-term cost of managing disease because it helps catch problems in the early stages when most diseases are more readily treatable. The cost of early treatment or diet or lifestyle changes is less than the cost of treating and managing a full-blown chronic disease or serious illness.



# BENEFIT TERMS

The world of health insurance has many terms that can be confusing. Understanding your costs and benefits—and estimating the price of a visit to the doctor—becomes much easier once you are able to make sense of the terminology.

## Definitions

- **Annual limit**—Cap on the benefits your insurance company will pay in a given year while you are enrolled in a particular health insurance plan.
- **Claim**—A bill for medical services rendered.
- **Cost-sharing**—Health care provider charges for which a patient is responsible under the terms of a health plan. This includes deductibles, coinsurance and copayments.
- **Coinsurance**—Your share of the costs of a covered health care service calculated as a percentage of the allowed amount for the service.
- **Copayment (copay)**—A fixed amount you pay for a covered health care service, usually when you receive the service.
- **Deductible**—The amount you owe for health care services each year before the insurance company begins to pay. Example: John has a health plan with a \$1,000 annual deductible. John falls off his roof and has to have three knee surgeries, the first of which is \$800. Because John hasn't paid anything toward his deductible yet this year, and because the \$800 surgery doesn't meet the deductible, John is responsible for 100 percent of his first surgery.
- **Dependent Coverage**—Coverage extended to the spouse and children of the primary insured member. Age restrictions on the coverage may apply.
- **Explanation of Benefits (EOB)**—A statement sent from the health insurance company to a member listing services that were billed by a provider, how those charges were processed and the total amount of patient responsibility for the claim.
- **Group Health Plan**—A health insurance plan that provides benefits for employees of a business.
- **In-network Provider**—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.
- **Inpatient Care**—Care rendered in a hospital when the duration of the hospital stay is at least 24 hours.
- **Insurer (carrier)**—The insurance company providing coverage.
- **Insured**—The person with the health insurance coverage. For group health insurance, your employer will typically be the policyholder and you will be the insured.
- **Open Enrollment Period**—Time period during which eligible persons may opt to sign up for coverage under a group health plan.
- **Out-of-network Provider**—A provider who is not contracted with your health insurance company.
- **Out-of-pocket Maximum (OOPM)**—The maximum amount you should have to pay for your health care during one year, excluding the monthly premium. After you reach the annual OOPM, your health insurance or plan begins to pay 100 percent of the allowed amount for covered health care services or items for the rest of the year.
- **Outpatient Care**—Care rendered at a medical facility that does not require overnight hospital admittance or a hospital stay lasting 24 hours or more.
- **Policyholder**—The individual or entity that has entered into a contractual relationship with the insurance carrier.
- **Premium**—Amount of money charged by an insurance company for coverage.
- **Preventive Care**—Medical checkups and tests, immunizations and counseling services used to prevent chronic illnesses from occurring.
- **Provider**—A clinic, hospital, doctor, laboratory, health care practitioner or pharmacy.
- **Qualifying Life Event**—A life event designated by the IRS that allows you to amend your current plan or enroll in new health insurance. Common life events include marriage, divorce, and having or adopting a child.
- **Qualified Medical Expense**—Expenses defined by the IRS as the costs attached to the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body.
- **Summary of Benefits and Coverage (SBC)**—An easy-to-read outline that lets you compare costs and coverage between health plans.

## Acronyms

- **ACA**—Affordable Care Act
- **CDHC**—Consumer driven or consumer directed health care
- **CDHP**—Consumer driven health plan
- **CHIP**—The Children's Health Insurance Program. A program that provides health insurance to low-income children, and in some states, pregnant women who do not qualify for Medicaid but cannot afford to purchase private health insurance.
- **CPT Code**—Current procedural terminology code. A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities, such as physicians, health insurance companies and accreditation organizations.
- **FPL**—Federal poverty level. A measure of income level issued annually by the Department of Health and Human Services (HHS) and used to determine eligibility for certain programs and benefits.
- **FSA**—Flexible spending account. An employer-sponsored savings account for health care expenses.
- **HDHP**—High deductible health plan
- **HMO**—Health maintenance organization
- **HRA**—Health reimbursement arrangement. An employer-funded arrangement that reimburses employees for certain medical expenses.
- **HSA**—Health savings account. A tax-advantaged savings account that accompanies HDHPs.
- **OOP**—Out-of-pocket limit. The maximum amount you have to pay for covered services in a plan year.
- **PCE**—Pre-existing condition exclusion. A plan provision imposing an exclusion of benefits due to a pre-existing condition.
- **PPO**—Preferred provider organization. A type of health plan that contracts with medical providers (doctors and hospitals) to create a network of participating providers. You pay less when using providers in the plan's network, but can use providers outside the network for an additional cost.
- **QHP**—Qualified health plan. A certified health plan that provides an essential health benefits package. Offered by a licensed health insurer.

# ANNUAL REQUIRED NOTICES

## Leech Lake Band of Ojibwe Indians Health Law Notices

### **Michelle's Law Notice**

If there is a medically necessary leave of absence from a post-secondary educational institution or other change in enrollment that: (1) begins while a dependent child is suffering from a serious illness or injury; (2) is certified by a physician as being medically necessary; and (3) causes the dependent child to lose student status for purposes of coverage under the plan, that child may maintain dependent eligibility for up to one year. If the treating physician does not provide written documentation when requested by the Plan Administrator that the serious illness or injury has continued, making the leave of absence medically necessary, the plan will no longer provide continued coverage.

### **Benefits During Family Medical Leave**

Assuming the Plan Administrator meets certain criteria during the preceding calendar year, the Plan will comply with the Family and Medical Leave Act (FMLA) of 1993 as amended, which provides benefit continuation rights during an approved medical leave of absence. If the Plan Administrator is subject to the law, an employee and any dependents covered under a health benefit plan may be eligible to continue the coverage under that plan for a certain period of time.

Any employer contributions made under the terms of the Plan shall continue to be made on behalf of such employee electing to maintain coverage while on FMLA leave. An employee on FMLA leave must make any applicable contributions to maintain coverage. To the extent required under the FMLA and in accordance with procedures established by the Plan Administrator such employee contributions may be payable:

- prior to the employee taking the leave; or
- during the leave; or
- repaid to the employer through payroll deductions upon return to work following the leave.

Contact the Plan Administrator for additional information on the FMLA leave policy or to request leave. Certain rights under specific state family leave laws may also apply.

### **Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)**

Under USERRA, an employer is required to offer COBRA-like continuation of coverage to covered employees in the uniformed services if their absence from work during military duty would result in a loss of coverage as a result of such active duty. The maximum length of USERRA continuation of coverage is the lesser of 24 months beginning on the date of the employee's departure, or the period beginning on the date of the employee's departure and ending on the date on which the employee failed to return from active

duty or apply for reemployment within the time allowed by USERRA. If an employee elects to continue coverage pursuant to USERRA, such employee, and any covered dependents, will be required to pay up to 102% of the full premium for coverage elected. For military leaves of 30 days or less, the employee is not required to contribute more than the amount he or she would have paid as an active employee. Continued coverage under this provision pursuant to USERRA will reduce any coverage continuation provided under COBRA Continuation.

### **Premium Assistance Under Medicaid and The Children's Health Insurance Program (CHIP) – Applies to Group Health Plans Only**

If an Employee or an Employee's children are eligible for Medicaid or CHIP and are eligible for health coverage from an employer, the state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If the Employee or his/her children are not eligible for Medicaid or CHIP, they will not be eligible for these premium assistance programs but they may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit [www.healthcare.gov](http://www.healthcare.gov).

If an Employee or his/her dependents are already enrolled in Medicaid or CHIP and they live in a State listed below, contact they may State Medicaid or CHIP office to find out if premium assistance is available.

If an Employee or his/her dependents are NOT currently enrolled in Medicaid or CHIP, and they think they (or any of their dependents) might be eligible for either of these programs, they can contact the State Medicaid or CHIP office or dial **1-877-KIDS NOW** or [www.insurekidsnow.gov](http://www.insurekidsnow.gov) to find out how to apply. If they qualify, ask if the state has a program that might help pay the premiums for an employer-sponsored plan.

If an Employee or his/her dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under their employer plan, the employer must allow the Employee to enroll in the employer plan if they are not already enrolled. This is called a "special enrollment" opportunity, and **the Employee must request coverage within 60 days of being determined eligible for premium assistance**. If the Employee has questions about enrolling in the employer's plan, contact the Department of Labor at [www.askebsa.dol.gov](http://www.askebsa.dol.gov) or call **1-866-444-EBSA (3272)**.

**Employees living in one of the following States, may be eligible for assistance paying employer health plan premiums. The following list of States is current as of July 31, 2020. The most recent CHIP notice can be found at <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra>. Contact the respective State for more information on eligibility –**

### **ALABAMA-Medicaid**

Website: <http://myalhipp.com/>  
Phone: 1-855-692-5447

### **ALASKA-Medicaid**

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>

### **ARKANSAS-Medicaid**

Website: <http://myarhipp.com/>  
Phone: 1-855-MyARHIPP (855-692-7447)

### **COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**

Health First Website: <https://www.healthfirstcolorado.com/>  
Phone: 1-800-221-3943  
CHP+ Website: <https://www.colorado.gov/pacific/hcpf/child-health-plan-plus>  
Phone: 1-800-359-1991  
Health Insurance Buy-In Program (HIBI): <https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program>  
Phone: 1-855-692-6442

### **FLORIDA-Medicaid**

Website: <https://www.flmedicaidtprecovery.com/flmedicaidprecovery.com/hipp/index.html>  
Phone: 1-877-357-3268

### **GEORGIA-Medicaid**

Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>  
Phone: 678-564-1162 ext 2131

### **INDIANA-Medicaid**

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

### **IOWA-Medicaid and CHIP (Hawki)**

Medicaid Website: <https://dhs.iowa.gov/ime/members>  
Phone: 1-800-338-8366  
Hawki Website: <http://dhs.iowa.gov/Hawki>  
Phone: 1-800-257-8563

### **KANSAS – Medicaid**

Website: <http://www.kdheks.gov/hcf/default.htm>  
Phone: 1-800-792-4884

### **KENTUCKY-Medicaid**

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:

<https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>  
Phone: 1-855-459-6328  
KCHIP Website:  
<https://kidshealth.ky.gov/Pages/index.aspx>  
Phone: 1-877-524-4718  
Medicaid Website: <https://chfs.ky.gov>

#### **LOUISIANA-Medicaid**

Website: [www.medicaid.la.gov](http://www.medicaid.la.gov) or  
[www.ldh.la.gov/lahipp](http://www.ldh.la.gov/lahipp)  
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

#### **MAINE-Medicaid**

Enrollment Website:  
<https://www.maine.gov/dhhs/ofi/applications-forms>  
Phone: 1-800-442-6003  
Private Health Insurance Premium Webpage:  
<https://www.maine.gov/dhhs/ofi/applications-forms>  
Phone: 1-800-977-6740

#### **MASSACHUSETTS-Medicaid and CHIP**

Website:<http://www.mass.gov/eohhs/gov/departments/masshealth/>  
Phone: 1-800-862-4840

#### **MINNESOTA-Medicaid**

<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

#### **MISSOURI-Medicaid**

Website:<http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>  
Phone: 573-751-2005

#### **MONTANA-Medicaid**

Website:<http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>  
Phone: 1-800-694-3084

#### **NEBRASKA-Medicaid**

Website: <http://www.ACCESSNebraska.ne.gov>  
Phone: (855) 632-7633  
Lincoln: (402) 473-7000  
Omaha: (402) 595-1178

#### **NEVADA-Medicaid**

Medicaid Website: <http://dhcfp.nv.gov>  
Phone: 1-800-992-0900

#### **NEW HAMPSHIRE-Medicaid**

Website: <https://www.dhhs.nh.gov/oi/hipp.htm>  
Phone: 603-271-5218  
Toll-Free: 1-800-852-3345, ext 5218

#### **NEW JERSEY-Medicaid and CHIP**

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

#### **NEW YORK-Medicaid**

Website:[https://www.health.ny.gov/health\\_care/medicaid/](https://www.health.ny.gov/health_care/medicaid/) Phone: 1-800-541-2831

#### **NORTH CAROLINA-Medicaid**

Website: <https://dma.ncdhhs.gov/> Phone: 919-855-4100

#### **NORTH DAKOTA-Medicaid**

Website:<http://www.nd.gov/dhs/services/medicalserv/medicaid/>  
Phone: 1-844-854-4825

#### **OKLAHOMA-Medicaid and CHIP**

Website: <http://www.insureoklahoma.org> Phone: 1-888-365-3742

#### **OREGON-Medicaid**

Website:  
<http://healthcare.oregon.gov/Pages/index.aspx>  
<http://www.oregonhealthcare.gov/index-es.html>  
Phone: 1-800-699-9075

#### **PENNSYLVANIA-Medicaid**

Website:<https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx>  
Phone: 1-800-692-7462

#### **RHODE ISLAND-Medicaid and CHIP**

Website: <http://www.eohhs.ri.gov/> Phone: 855-697-4347 or 401-462-0311 (Direct Rte Share Line)

#### **SOUTH CAROLINA-Medicaid**

Website: <https://www.scdhhs.gov>  
Phone: 1-888-549-0820

#### **SOUTH DAKOTA-Medicaid**

Website: <http://dss.sd.gov> Phone: 1-888-828-0059

#### **TEXAS-Medicaid**

Website: <http://gethiptexas.com/> Phone: 1-800-440-0493

#### **UTAH-Medicaid and CHIP**

Medicaid Website: <https://medicaid.utah.gov/>  
CHIP Website: <http://health.utah.gov/chip> Phone: 1-877-543-7669

#### **VERMONT-Medicaid**

Website: <http://www.greenmountaincare.org/>  
Phone: 1-800-250-8427

#### **VIRGINIA-Medicaid**

Website:<http://www.coverva.org/hipp>  
Medicaid Phone: 1-800-432-5924  
CHIP Phone: 1-855-242-8282

#### **WASHINGTON-Medicaid**

Website: <http://www.hca.wa.gov/>  
Phone: 1-800-562-3022

#### **WEST VIRGINIA-Medicaid**

Website: <http://mywvhipp.com/>  
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

#### **WISCONSIN-Medicaid and CHIP**

Website:  
<https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm> Phone: 1-800-362-3002

#### **WYOMING-Medicaid**

<https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>  
Phone: 1-800-251-1269

To see if any other States have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor  
Employee Benefits Security Administration  
[www.dol.gov/agencies/ebsa](http://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](http://www.cms.hhs.gov)  
1-877-267-2323, Menu Option 4, Ext. 61565

#### **Important Disclosures**

##### **Women's Health and Cancer Rights Act of 1998**

The Federal Women's Health and Cancer Rights Act of 1998 requires coverage of treatment related to mastectomy. If the participant is eligible for mastectomy benefits under health coverage and elects breast reconstruction in connection with such mastectomy, she is also covered for the following:

- Reconstruction of the breast on which mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses;
- Treatment of physical complications of all states of mastectomy, including lymphedemas.

Coverage for reconstructive breast surgery may not be denied or reduced on the ground that it is cosmetic in nature or that it otherwise does not meet the coverage definition of "medically necessary." Benefits will be provided on the same basis as for any other illness or injury under the Plan. Coverage for breast reconstruction and related services will be subject to applicable deductibles, co-payments and coinsurance amounts that are consistent with those that apply to other benefits under the Plan.

##### **Maternity Coverage Length of Hospital Stay**

Group health plans and health insurance issuers offering group health insurance coverage 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 normal 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 or 96 hours, as applicable. Additionally, no group health plan or issuer may require that a provider obtain authorization from the Plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

##### **Medical Child Support Orders**

A Component Benefit Plan must recognize certain legal documents presented to the Plan



Administrator by participants or their representatives. The Plan Administrator may be presented court orders which require child support, including health benefit coverage. The Plan Sponsor must recognize a Qualified Medical Child Support Order (QMCSO), within the meaning of ERISA section 609(a)(2)(B), under any Component Benefit Plan providing health benefit coverage.

A QMCSO is a state court or administrative agency order that requires an employer's medical plan to provide benefits to the child of an employee who is covered, or eligible for coverage, under the employer's plan. QMCSOs usually apply to a child who is born out of wedlock or whose parents are divorced. If a QMCSO applies, the employee must pay for the child's medical coverage and will be required to join the Plan if not already enrolled.

The Plan Administrator, when receiving a QMCSO, must promptly notify the employee and the child that the order has been received and what procedures will be used to determine if the order is "qualified." If the Plan Administrator determines the order is qualified and the employee must provide coverage for the child pursuant to the QMCSO, contributions for such coverage will be deducted from the employee's paycheck in an amount necessary to pay for such coverage. The affected employee will be notified once it is determined the order is qualified. Participants and beneficiaries can obtain a copy of the procedure governing QMCSO determinations from the Plan Administrator without charge.

#### **New Health Insurance Marketplace Coverage Options and Your Health Coverage**

##### **PART A: General Information**

When key parts of the health care law took effect in 2014, a new way to buy health insurance became available: the Health Insurance Marketplace. To assist Employees as they evaluate options for themselves and their family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by their employer.

##### **What is the Health Insurance Marketplace?**

The Marketplace is designed to help individuals and families find health insurance that meets their needs and fits their budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. Employees may also be eligible for a new kind of tax credit that lowers their monthly premium right away. The open enrollment period for health insurance coverage through the Marketplace began on Nov. 1<sup>st</sup>, and ended on Dec. 15. Individuals must have enrolled or changed plans prior to Dec. 15, for coverage starting as early as Jan. 1<sup>st</sup>. After Dec. 15<sup>th</sup>, individuals can get coverage through the Marketplace only if they qualify for a special enrollment period.

##### **Can individuals Save Money on Health Insurance Premiums in the Marketplace?**

Individuals may qualify to save money and lower monthly premiums, but only if their employer does not offer coverage, or offers coverage that doesn't

meet certain standards. The savings on premiums depends on household income.

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

Yes. If the Employee has an offer of health coverage from his/her employer that meets certain standards, they will not be eligible for a tax credit through the Marketplace and may wish to enroll in their employer's health plan. However, an individual may be eligible for a tax credit that lowers their monthly premium, or a reduction in certain cost-sharing if their employer does not offer coverage at all or does not offer coverage that meets certain standards. If the cost of a plan from an employer that would cover the Employee (and not any other members of their family) is more than 9.56% of household income for the year, or if the coverage the employer provides does not meet the "minimum value" standard set by the Affordable Care Act, the Employee may be eligible for a tax credit. \*

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

##### **How Can Individuals Get More Information?**

For more information about coverage offered by the Employer, please check the summary plan description or contact Human Resources.

The Marketplace can help when evaluating coverage options, including 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 the area.

\*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% of such costs.

##### **Special Enrollment Periods**

**Special Enrollment Rights** – If an employee declines enrollment for him/herself or for their dependents (including their spouse) because of other health insurance coverage, they may be able to enroll him/herself or their dependents in this Plan in the future, provided they request enrollment within 30 days after their other coverage ends. Coverage will begin under this Plan on the first day of the month after the Plan receives the enrollment form.

If an employee acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption, they may be able to enroll him/herself and their dependents provided that they request enrollment within 30 days after the

marriage, birth, adoption, or placement for adoption. If an employee adds coverage under these circumstances, they may add coverage mid-year. For a new spouse or dependent acquired by marriage, coverage is effective no later than the first day of the first month beginning after the date the plan receives a timely request for the enrollment. When a new dependent is acquired through birth, adoption, or placement for adoption, coverage will become effective retroactive to the date of the birth, adoption, or placement for adoption. The plan does not permit mid-year additions of coverage except for newly eligible persons and special enrollees.

##### **Individuals gaining or losing Medicaid or State Child Health Insurance Coverage (SCHIP) - If an employee or their dependent was:**

1. covered under Medicaid or a state child health insurance program and that coverage terminated due to loss of eligibility, or becomes eligible for premium assistance under Medicaid or state child health insurance program, a special enrollment period under this Plan will apply. The employee must request coverage under this Plan within 60 days after the termination of such Medicaid or SCHIP, or within 60 days of becoming eligible for the premium assistance from Medicaid or the SCHIP. Coverage under the plan will become effective on the date of termination of eligibility for Medicaid/state child health insurance program, or the date of eligibility for premium assistance under Medicaid or SCHIP.
- 2.

#### **HIPAA Notice of Privacy Practices** **Effective Date: March 1, 2013**

***THIS NOTICE DESCRIBES HOW INDIVIDUAL MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW TO GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.***

#### **HIPAA Notice of Privacy Practices**

The Leech Lake Band of Ojibwe Indians Group Medical Plan (the "Plan"), which includes medical and dental coverages offered under the Leech Lake Band of Ojibwe Indians Plans, are required by law (under the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 HIPAA's privacy rule) to take reasonable steps to ensure the privacy of personally identifiable health information. This Notice is

being provided to inform employees (and any of their dependents) of the policies and procedures Leech Lake Band of Ojibwe Indians has implemented and their rights under them, as well as under HIPAA. These policies are meant to prevent any unnecessary disclosure of individual health information.

Use and Disclosure of Individually Identifiable Health Information by the Plan that Does Not Require the Individual's Authorization: The plan may use or disclose health information (that is protected health information (PHI)), as defined by HIPAA's privacy rule) for:

#### **1. Payment and Health Care**

**Operations:** In order to make coverage determinations and payment (including, but not limited to, billing, claims management, subrogation, and plan reimbursement). For example, the Plan may provide information regarding an individual's coverage or health care treatment to other health plans to coordinate payment of benefits. Health information may also be used or disclosed to carry out Plan operations, such as the administration of the Plan and to provide coverage and services to the Plan's participants. For example, the Plan may use health information to project future benefit costs, to determine premiums, conduct or arrange for case management or medical review, for internal grievances, for auditing purposes, business planning and management activities such as planning related analysis, or to contract for stop-loss coverage. Pursuant to the Genetic Information Non-Discrimination Act (GINA), the Plan does not use or disclose genetic information for underwriting purposes.

**2. Disclosure to the Plan Sponsor:** As required, in order to administer benefits under the Plan. The Plan may also provide health information to the plan sponsor to allow the plan sponsor to solicit premium bids from health insurers, to modify the Plan, or to amend the Plan.

**3. Requirements of Law:** When required to do so by any federal, state or local law.

**4. Health Oversight Activities:** To a health oversight agency for activities such as audits, investigations, inspections, licensure, and other proceedings related to the oversight of the health plan.

**5. Threats to Health or Safety:** As required by law, to public health authorities if the Plan, in good faith, believes the disclosure is necessary to prevent or lessen a serious or imminent threat to an individual's health or safety or to the health and safety of the public.

**6. Judicial and Administrative Proceedings:** In the course of any administrative or judicial proceeding in response to an order from a court or administrative tribunal, in response to a subpoena, discovery request or other similar process. The Plan will make a good faith attempt to provide written notice to the individual to allow them to raise an objection.

**7. Law Enforcement Purposes:** To a law enforcement official for certain enforcement purposes, including, but not limited to, the purpose of identifying or locating a suspect, fugitive, material witness or missing person.

**8. Coroners, Medical Examiners, or Funeral Directors:** For the purpose

of identifying a deceased person, determining a cause of death or other duties as authorized by law.

**9. Organ or Tissue Donation:** If the person is an organ or tissue donor, for purposes related to that donation.

#### **10. Specified Government**

**Functions:** For military, national security and intelligence activities, protective services, and correctional institutions and inmates.

**11. Workers' Compensation:** As necessary to comply with workers' compensation or other similar programs.

#### **12. Distribution of Health-Related**

**Benefits and Services:** To provide information to the individual on health-related benefits and services that may be of interest to them.

#### **Notice in Case of Breach**

Leech Lake Band of Ojibwe Indians is required maintain the privacy of PHI; to provide individuals with this notice of the Plan's legal duties and privacy practices with respect to PHI; and to notify individuals of any breach of their PHI.

#### **Use and Disclosure of Individual Health Information by the Plan that Does Require Individual**

**Authorization:** Other than as listed above, the Plan will not use or disclose without your written authorization. You may revoke your authorization in writing at any time, and the Plan will no longer be able to use or disclose the health information. However, the Plan will not be able to take back any disclosures already made in accordance with the Authorization prior to its revocation. The following uses and disclosures will be made

only with authorization from the individual: (i) most uses and disclosures of psychotherapy notes (if recorded by a covered entity); (ii) uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this notice.

**Individual Rights with Respect to Personal Health Information:** Each individual has the following rights under the Plan's policies and procedures, and as required by HIPAA's privacy rule:

**Right to Request Restrictions on Uses and Disclosures:** An individual may request the Plan to restrict uses and disclosures of their health information. The Plan will accommodate reasonable requests; however, it is not required to agree to the request, unless it is for services paid completely by the individual out of their own pocket. A wish to request a restriction must be sent in writing to HIPAA Privacy Officer, at Leech Lake Band of Ojibwe Indians, 190 Sailstar Drive NW, Cass Lake, MN 56633, (218) 335-8200.

**Right to Inspect and Copy Individual Health Information:** An individual may inspect and obtain a copy of their individual health information maintained by the Plan. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. A written request must be provided to HIPAA Privacy Officer at Leech Lake Band of Ojibwe Indians, 190

Sailstar Drive NW, Cass Lake, MN 56633, (218) 335-8200. If the individual requests a copy of their health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with their request.

**Right to Amend Your Health Information:** You may request the Plan to amend your health information if you feel that it is incorrect or incomplete. The Plan has 60 days after the request is made to make the amendment. A single 30-day extension is allowed if the Plan is unable to comply with this deadline. A written request must be provided to HIPAA Privacy Officer, at Leech Lake Band of Ojibwe Indians, 190 Sailstar Drive NW, Cass Lake, MN 56633, (218) 335-8200. The request may be denied in whole or part and if so, the Plan will provide a written explanation of the denial.

**Right to an Accounting of Disclosures:** An individual may request a list of disclosures made by the Plan of their health information during the six years prior to their request (or for a specified shorter period of time). However, the list will not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) disclosures made prior to April 14, 2004; (3) to individuals about their own health information; and (4) disclosures for which the individual provided a valid authorization.

A request for an accounting form must be used to make the request and can be obtained by contacting the HIPAA Privacy Officer at Leech Lake Band of Ojibwe Indians, 190 Sailstar Drive NW, Cass Lake, MN 56633, (218) 335-8200. The

accounting will be provided within 60 days from the submission of the request form. An additional 30 days is allowed if this deadline cannot be met.

**Right to Receive Confidential Communications:** An individual may request that the Plan communicate with them about their health information in a certain way or at a certain location if they feel the disclosure could endanger them. The individual must provide the request in writing to the HIPAA Privacy Officer at Leech Lake Band of Ojibwe Indians, 190 Sailstar Drive NW, Cass Lake, MN 56633, (218) 335-8200. The Plan will attempt to honor all reasonable requests.

**Right to a Paper Copy of this Notice:** Individuals may request a paper copy of this Notice at any time, even if they have agreed to receive this Notice electronically. They must contact their HIPAA Privacy Officer at Leech Lake Band of Ojibwe Indians, 190 Sailstar Drive NW, Cass Lake, MN 56633, (218) 335-8200 to make this request.

**The Plan's Duties:** The Plan is required by law to maintain the privacy of individual health information as related in this Notice and to provide this Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains.

**Complaints and Contact Person:** If an individual wishes to exercise their rights under this Notice, communicate with the Plan about its



privacy policies and procedures, or file a complaint with the Plan, they must contact the HIPAA Contact Person, at Leech Lake Band of Ojibwe Indians, 190 Sailstar Drive NW, Cass Lake, MN 56633, (218) 335-8200. They may also file a complaint with the Secretary of Health and Human Services if they believe their privacy rights have been violated.

## **Important Notice from Leech Lake Band of Ojibwe Indians About Your Prescription Drug Coverage and Medicare (Creditable Coverage)**

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Leech Lake Band of Ojibwe Indians 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. Leech Lake Band of Ojibwe Indians has determined that the prescription drug coverage offered by the Leech Lake Band of Ojibwe Indians Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your

existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

### **When Can You Join A Medicare Drug Plan?**

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

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

### **What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?**

If you decide to join a Medicare drug plan, your current Leech Lake Band of Ojibwe Indians coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Leech Lake Band of Ojibwe Indians coverage, be aware that you and your dependents will 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 Leech Lake Band of Ojibwe Indians 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 Leech Lake Band of Ojibwe Indians 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](http://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](http://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: 9.20.2020

Name of Entity/Sender: Leech Lake Band of Ojibwe Indians

Contact--Position/Office: Human Resources

Address: 190 Sailstar Drive NW, Cass Lake, MN 56633

Phone Number: (218) 335-8200

