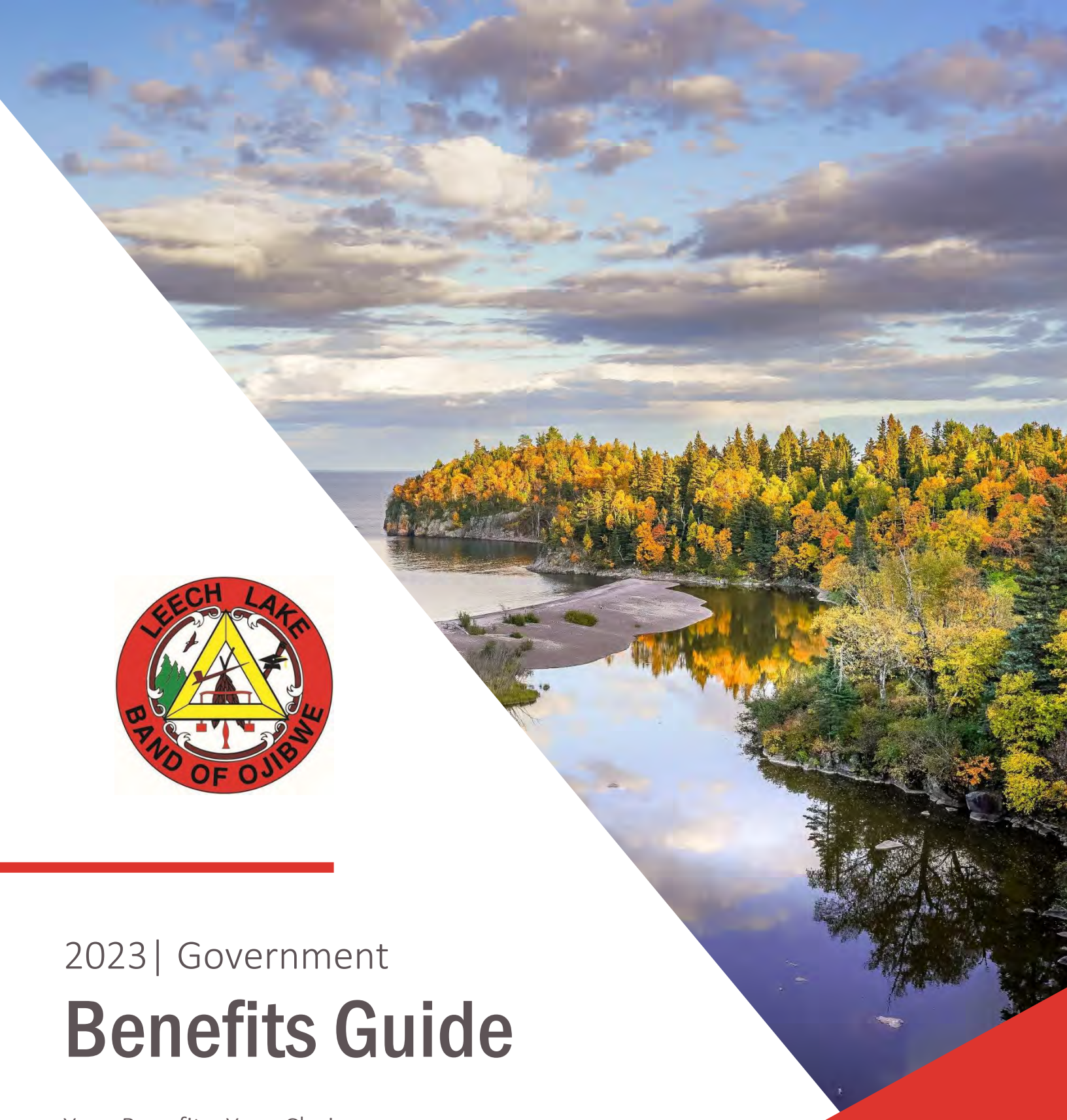

2023| Government

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	www.myQCCbluelink.com
Prescription Drug Coverage	ClearScript Rx	1-855-816-6389	www.clearscript.org
Prescription Drug Coverage Prior Auth	ClearScript Rx	1-877-355-0321	www.clearscript.org
Dental Insurance	Delta Dental	1-800-553-9536	www.deltadentalmn.org
Long-Term Disability Income	Unum	1- 866-679-3054	services.unum.com
Critical Illness, Accident	Unum	1- 866-679-3054	services.unum.com
Basic Life, AD&D, Voluntary Life & AD&D Insurance and Short-Term Disability	The Hartford	1-888-563-1124	www.thehartford.com
401(k)	Ascensus	1-866-809-8146	www.myaccount.ascensus.com

Human Resources Contact Information

HR Contact	Position	Phone Number	Email
Jaimie Myers	Leech Lake Government	218-335-3613	jaimie.myers@llojibwe.net

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

Medical Eligibility Requirements

Class I Employees: Full time employees of the Bug-O-Nay-Ge-Shig School, Head Start Program or Heritage Sites Program working a minimum of 30 hours per week. Bug School: Full time employees are eligible the first day of the school year if working full time on that date; or first of the month after they are hired if hired during the school year. Head Start and Heritage Sites: Full time employees are eligible the first of the month after they are hired.

Class III Employees: All full time employees of the LLBO not identified under any other Class, who work for a minimum of thirty 30 hours per week. Eligible first of the month following six (6) months of full-time continuous employment.

Class IV Employees: Full time employees of the Leech Lake Department of Public Safety and Division of Resource Management who work a minimum of 30 hours per week. Eligible first of the month after they are hired.

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 2022. These are subject to change. If you have questions or concerns, please speak with Human Resources.

Medical Insurance	Per Paycheck
PPO $400 Plan	
Employee Only	$79.45
Family	$228.58
$6,350 HDHP with HSA	
Employee Only	$47.10
Family	$135.42

$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

Any mailings you receive from **BlueLink** or **Delta Dental** should be responded to as soon as possible.

All responses are to be sent directly back to BlueLink or Delta Dental.

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

Medical Insraunce	
Benefit Cost	See page 5.

MEDICAL INSURANCE
(CONT.)

BlueLink TPA

Additional Information

If you have any questions concerning coverage or claims resolutions, you can call the numbers located on the last page of this booklet or on the back of your ID cards.

You may choose to waive the medical and dental insurance by completing the waiver portion of the Group Coverage form and a HIPAA form.

Termination of Coverage

If an employee terminates employment, or drops to part time, coverage will remain in effect until the last day of the month of termination or change to part time status. For insurance purposes, the date in which the Employee's employment is terminated will determine the last day for insurance coverage. Example: employee last works on June 15th, the last day of coverage for insurance will be June 30th. If that employee has been deducted premiums into the next month, it is up to the employee to notify the Benefits Department for reimbursement.

Continuation of Benefits (COBRA)

Is offered to employees who drop to part time or have terminated employment as long as there was no gross misconduct. Coverage continuation information will be sent to the employee from BCBS.

Working Spouse Provision

In many families, both adults work and many spouses have access to medical coverage through their employers. In order to reduce rising health care costs, some employers have adopted group health plan provisions restricting coverage of working spouses. Working spousal provisions were created with the philosophy of ensuring that other employers pay their fair share of employee healthcare expenses. A working dependent would be a spouse who is working and eligible for benefits with their employer.

The LLBO Group Health Plan contains a working spouse coverage provision. This provision applies if your spouse is eligible for coverage through his/her employer regardless of the cost of coverage or the level of benefit provided. Your spouse must enroll in his/her employer's health plan or he/she will not be eligible for benefits under the LLBO group medical plan.

This requirement does not apply if:

- Your spouse is self-employed or
- Your spouse is an active employee under the LLBO group health plan, or
- Your spouse is not eligible for insurance coverage under his/her employer's medical plan.

Included in your new hire benefit pack is a Working Spouse Coverage Statement with the medical/dental coverage application. If your spouse's situation changes during the year, new forms can be obtained by calling the Benefits Department. This form must be filled out by you and your spouse and your spouse's employer (if applicable). The completed, signed form must be returned to the Benefits Department no later than **30 days after your employment date**.

If your spouse's access to employer coverage changes, due to job loss or new job that offers medical coverage, it is your responsibility to notify the LLBO Benefits Department **within thirty (30) days** of the change. If your fail to notify Leech Lake Government or if your notification is found to be dishonest, it will be considered falsification of records.

If you have any questions, please contact the Benefits Department.

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.

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
Calendar Year Deductible			
Individual	$50/person	$50/person	$50/person
Family	$150/family	$150/family	$150/family
Annual Out-of-Pocket Max	$1,500	$1,500	$1,500
Ortho Lifetime Max	$1,500	$1,500	$1,500
Coverages	**In-Network**	**Out-of-Network**	**Non-Participating**
Preventative Care	100%	100%	100%
Basic Services	80%	80%	80%
Major Services	70%	70%	70%
Orthodontia Services (Up to age 19)	50%	50%	50%

Dental Insurance Rates	
See page 5.	

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	
Coverage Amounts	**Employees working 30 or more hours per week:** $30,000
Reduction Schedule	65% at age 65 and 50% at age 70
Benefit Cost	100% paid by Leech Lake Band of Ojibwe

Basic Life/AD&D Insurance – Dependent Coverage	
Coverage Amounts	**Legal Spouse:** $5,000 **Minor Children:** $2,500
Benefit Cost	$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	
Coverage Amounts	**Employee:** $10,000 increments up to $300,000 **Spouse:** $5,000 increments to $150,000 not to exceed 50% of Employee Amount **Dependent Child(ren):** Up to $10,000 depending on your child's age
Guarantee Issue Amounts	**Employee:** $100,000 **Spouse:** $50,000 **Children:** 10,000
Reduction Schedule	65% at age 65 and 50% at age 70

For more information about rates, please contact Joy Devault.

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	
Elimination Period	Zero (0) days – Injury Seven (7) days – Sickness
Benefit Percentage	67%
Maximum Weekly Benefit	Up to $450 per week
Maximum Period of Payment	26 weeks
Benefit Cost	100% paid by Leech Lake Band of Ojibwe

Eligibility

Class I Employees: Full time employees of the Bug-O-Nay-Ge-Shig School, Head Start Program or Heritage Sites Program working a minimum of 37 hours per week. Bug School: Full time employees are eligible the first day of the school year if working full time on that date; or the first of the month after they hired if they are hired during the school year. Head Start and Heritage Sites: Full time employees are eligible first of the month after they are hired.

Class III Employees: All other full time employees of the Leech Lake Band of Ojibwe not identified under any other class, who work a minimum of 35 hours per week. Eligible first of the month following (6) six months of full-time continuous employment.

Class IV Employees: Full time employees of the Leech Lake Department of Public Safety and Division of Resource Management who work a minimum of 35 hours per week. Eligible date of hire.

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.

How do I submit a claim?

Step 1: Know when it's time to file a claim. If you're absent from work, we can advise you on when to file a claim. If your absence is scheduled, such as an upcoming hospital stay, call us 30 days prior to your last day of work. If unscheduled, please call us as soon as possible.

Step 2: Have this information ready. 1. Name, address and other key identification information. 2. Name of your department and last full day of active work. 3. The nature of your claim or leave request. 4. Your treating physician's name, address, phone and fax numbers.

Step 3: Make the call or file online. With your information handy, call The Hartford at 1-800-549-6514. Or file online at WWW.THEHARTFORD.COM/MYBENEFITS. You'll be assisted by a caring professional who'll take your information, answer your questions and file your claim or process your leave request.

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 Government Benefits staff.

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.

VOLUNTARY LONG-TERM DISABILITY

Unum

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

Long-Term Disability Insurance	
Elimination Period	180 days or the date your Short-Term Disability payments end
Benefit Percentage	60%
Maximum Monthly Benefit	$5,000
Pre-existing Conditions Limitation	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.
Maximum Benefit Period	If under age 60. If over the age of 60, see Summary Plan Description for details.
Additional Features	Employee Assistance Program

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.

For more information about rates, please see Joy Devault.

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	
Benefit Amount	**Employees:** $5,000 to $50,000, in $1,000 increments **Spouse:** $5,000 to $30,000, in $1,000 increments **Dependent Children:** $2,500 to $5,000
Payment	Benefits are paid directly to the insured on a post-tax basis.
Portability	This plan is portable, so you may continue coverage if you leave the Band for any reason.
Health Screening Benefit	This benefit pays $50 per calendar year, per insured individual, if a covered health-screening test is performed.
Reduction Schedule	Policy amount reduces 50% at age 70.
Exclusions and Limitations	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.
Benefit Cost	Please see Jaimie Myers 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	
Eligibility	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 disable and/or married.
Hospital Sickness Confinement Rider	You have the option to add a Hospital Sickness Confinement Rider, which would pay if in the hospital for a covered illness.
Guarantee Issue	Coverage is Guarantee Issue, no medical questions are asked.
Portability	The plan is portable, so you may continue coverage if you leave the Band.
Benefit Cost	Please see Jaimie Myers 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	
Hospital Admission	$1,500 for each covered hospital admission (once per calendar year)
Hospital Stay	$100 for each day of your covered hospital stay, up to 60 days per calendar year
Hospital Intensive Care Unit (ICU) Confinement	$200 for each day of covered hospital intensive care unit confinement, up to 15 days per calendar year
Emergency Room Treatment*	$150 per insured per calendar year
Ambulance Transport*	$100 per trip, once per calendar year
Air Ambulance Transport*	$500 per trip, once per calendar year
Benefit Cost	Please see Jaimie Myers for rates.

*Accident only.

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.

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

INFORMATION FOR THOSE ELIGIBLE FOR MEDICARE

What Are My Options Once I Turn 65?

Will you retire or will you decide to stay in the workforce?
If you continue to work full-time, you may remain on the Band medical plan as long as you meet eligibility requirements. However, you may also be eligible for Medicare and a supplement policy that costs you less out-of-pocket. Please read the summary below and explore your options.

Working Beyond Age 65

Save some money:
If you are purchasing medical insurance through your employer, a Medicare plan could help you save money on your health care expenses. Medicare can coordinate with your employer-sponsored coverage or be purchased in lieu of it. It may make sense for you to sign up for Medicare in addition to or instead of the coverage you have today.

It starts with basic coverage at no cost (Part A):
Many people who choose to work past age 65 enroll in Part A (Hospital Coverage) because there is no monthly premium. Many choose to enroll in both Parts A and B together. Part B (Physician Coverage) requires a small monthly premium. A Supplement Plan, along with a Medicare Part D (Prescription coverage) plan, can also be purchased to cover most out-of-pocket costs for a very affordable premium. In some cases, these options are far less costly than staying on an employer sponsored plan. It is recommended that you explore all options to determine what is best for you. You may also shop for and change plans each year based on your specific needs.

Understanding Your Options

If you continue working:
If you are enrolled in Medicare, your coverage can either coordinate with the Band plan or it can be elected separately. Paying for both may not be cost effective.

An employee still working may drop the Band medical plan to enroll in Medicare and/or a Medicare Supplement Policy certain points throughout the year as long as there is a Qualifying event– as this is considered a Qualifying Event. You just need to prove that you had creditable coverage past your Initial Enrollment Period for Medicare.

Making changes to your Medicare plans:
Health care needs can change from year to year. Be sure to review your needs (upcoming surgeries, current prescription drugs, new wellness goals) so you can find a plan to best meet them.

Medicare open enrollment period
You can enroll in or change your plan once a year during the Open Enrollment Period (OEP) even if you do not have a qualifying event. The OEP is a seven-week period from October 15 through December 7.

Retiring At or After Age 65

Are you ready?
Whether you retire or decide to work part-time, once you turn age 65 you will be eligible for Medicare (Parts A and B) and other Medicare Supplement Plans. If you don't have employer-sponsored coverage, you should consider enrolling during your Initial Enrollment Period. You can enroll any time within the 3 months before your 65th birthday month, your birthday month or 3 months after.

Multiple Medicare Resources Available

Our Medicare library is available 24/7 online. Here you can browse videos, download guides/presentations, listen to an agent and access information at your convenience.

Visit: www.employeenavigator.com/benefits/Account/Login

Login using the following credentials:

- USERNAME: Medicare
- PASSWORD: Medicare

You may also complete the **Permission to Contact Form** to speak to agent and receive assistance with questions related to Medicare as well as explore affordable options available based on your specific needs.

It is important to note that **Medicare resources and options vary by state.** Each state has a **SHIP** (Senior Health Insurance Information Program) that offers free education and assistance specific to their state. To find your state resource and get the number to speak to a licensed counselor, you may either **visit: www.shiptacenter.org, call 877-839-2675 or email: info@shiptacenter.org.**

Additional information (Government resources):
Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week or visit www.Medicare.gov.

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

Provider
The patient receives treatment. The doctor then sends the bill to the insurance Band.

Network
Appropriate discount for using an in-network provider is applied.

Bill
The bill for services is presented to the insurance Band. Payment responsibilities are calculated and divided between the patient and the insurance Band.

Insurance Band Payment, Explanation of Benefits
Insurance pays for its portion of the bill from the provider. A summary of charges and insurance payments is sent to the patient via the insurance Band.

Patient
Patient pays doctor's office for copayments, deductibles and/or coinsurance that he or she is responsible for.

Out-of-Network Bill

Provider
The patient receives treatment. The doctor then sends the bill to the insurance Band.

Bill
The bill for services is presented to the insurance Band. Payment responsibilities are calculated and divided between the patient and the insurance Band.

Insurance Band Payment, Explanation of Benefits
Insurance pays for its portion of the bill from the provider. A summary of charges and insurance payments is sent to the patient via the insurance Band.

Patient
Patient pays doctor's office for copayments, deductibles and/or coinsurance that he or she is responsible for.

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.

GOVERNMENT 401K PLAN/403B PLAN

1st National Bemidji Investment Services/Raymond James

Eligibility:

- Must be 18 years of age.
- Employee will become eligible after they complete 6 months of employment.

Contributions:

- Leech Lake will put in 4 % of employee's gross earnings.
- The employee may elect to defer up to 15 % of their gross earnings to a maximum of $20,500 for 2022 if under age 50, and $27,000 if you are over 50.
- Deductions for employee contributions are taken on a pre-tax basis.

Vesting Schedule for Leech Lake:

- Two years of employment = 20% vested.
- Three years of employment = 40 % vested.
- Four years of employment = 100 % vested. Provided you worked a **1,000 hours each of those years**.

You own the money **you have contributed (deductions)** at 100 % from day one.

Investment Information

- There are several different accounts available for investment of your 401(k) funds.
- A Financial Advisor from 1st National Bemidji Bank/Raymond James is available on a monthly basis to visit with employees concerning their investments or participants can call directly.
- Contact information: David Balmer, CFP, CPFA, Financial Advisor, RJFS / Telephone: 218-333-9613

Withdrawals:

- Termination of employment. **After 30-day waiting period**.
- In-service withdrawals:
  1. Attainment of age 60.
  2. Hardship withdrawals with **proper documentation** required:

Hardship Requirements
Payment of medical care expenses previously incurred by the participant or the participant's spouse or dependents, including expenses necessary to obtain medical care.
Costs related to the purchase of a participant's principal residence (not to include mortgage payments).
Payment of tuition, related educational fees, and room and board expenses for the next 12 months of post-secondary education for the participant or the participant's spouse, children or dependents.
Payments necessary to prevent eviction from or foreclosure on a mortgage on the participant's principal residence.
Payments for burial or funeral expenses for your deceased parent, spouse or children.
Expenses for the damage repair to your principal residence that would qualify for the casualty deduction under Code Section 165 (Any loss sustained during the tax year and not compensated for by insurance or otherwise. Copies of Code Section 165 are available in the Benefits Department).

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 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 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**.

If an Employee or his/her dependents are already enrolled in Medicaid or CHIP and they live in a State listed below, they may contact the 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 visit **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** 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, 2021. 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
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)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program
Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943 / State Relay 711
CHP+ Website:
https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service:
1-800-359-1991 / State Relay 771
Health Insurance Buy-In Program (HIBI) Website:
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.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
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
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
Email: KIHIPP.PROGRAM@ky.gov
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 or
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
TTY: Maine Relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine Relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

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: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Website: http://dhcfp.nv.gov
Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll-Free: 1-800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website:
http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website:
https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.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: 1-855-697-4347 or 401-462-0311 (Direct RIte 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://gethipptexas.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 and CHIP
Website:
https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-Free: 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
Website:
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other States have added a premium assistance program since July 31, 2021, 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

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:

a. Reconstruction of the breast on which mastectomy has been performed;

b. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
c. Prostheses;
d. Treatment of physical complications of all states of mastectomy, including lymphedema.

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. 1st, and ended on Dec. 15. Individuals must have enrolled or changed plans prior to Dec. 15, for coverage starting as early as Jan. 1st. After Dec. 15th, 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 9.61% 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
2. 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.

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 Group Medical Plan (the "Plan"), which includes medical HRA, dental and flexible spending account coverages offered under the Leech Lake Band of Ojibwe 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 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 Housing 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 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, 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, 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, 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, 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, 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, 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, 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 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 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 has determined that the prescription drug coverage offered by the Leech Lake Band of Ojibwe 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 coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Leech Lake Band of Ojibwe 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 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 changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 10/1/2021
Name of Entity/Sender: Leech Lake Band of Ojibwe
Contact--Position/Office: Human Resources
Address: 190 Sailstar Drive NW, Cass Lake, MN 56633
Phone Number: (218) 335-8200

APPLIES TO HIGH DEDUCTIBLE HEALTH PLAN ONLY

Important Notice from Leech Lake Band of Ojibwe About Your Prescription Drug Coverage and Medicare (Non-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 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three 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 High Deductible Health Plan has determined that the prescription drug coverage offered by Leech Lake Band of Ojibwe is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Leech Lake Band of Ojibwe high deductible health plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can keep your current coverage from Leech Lake Band of Ojibwe. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

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 decide to drop your current coverage with Leech Lake Band of Ojibwe, since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under the Leech Lake Band of Ojibwe high deductible health plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
Since the coverage under the Leech Lake Band of Ojibwe high deductible health plan, is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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 coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Leech Lake Band of Ojibwe coverage, be aware that you and your dependents will be able to get this coverage back.

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 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).

Date: 10/1/2022
Name of Entity/Sender: Leech Lake Band of Ojibwe
Contact--Position/Office: Human Resources
Address: 190 Sailstar Drive NW, Cass Lake, MN 56633
Phone Number: 218-335-3613