St. Croix Chippewa Indians of Wisconsin

2024

Benefits Guide

Behold our Heritage.
Share our Future.

Welcome to Your Employee Benefits Guide!

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. Within this guide, you will find the highlights of the benefits offered by St. Croix Chippewa Indians of Wisconsin.

Current Employees

If you take no action during your open enrollment period, your current benefit elections will roll over—**with the exception of your Flexible Spending Account**. 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.

Benefit Contacts		
Kelly Bertuleit	Benefits Director	715-349-2195 ext. 5306
Heidi Rand	Benefit Specialist	715-349-2195 ext. 5272
Christine Peterson	Benefit Specialist	715-656-3444 ext. 2616
Cheri LaBlanc	Benefit Specialist	715-986-4777 ext. 3116
Debbie Tucker	Workers Compensation Specialist	715-986-4777 ext. 3038

Benefit Highlights

- Contact Information
- Eligibility & Enrollment
- Employee Contributions
- Health Insurance
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- Benefit Terms
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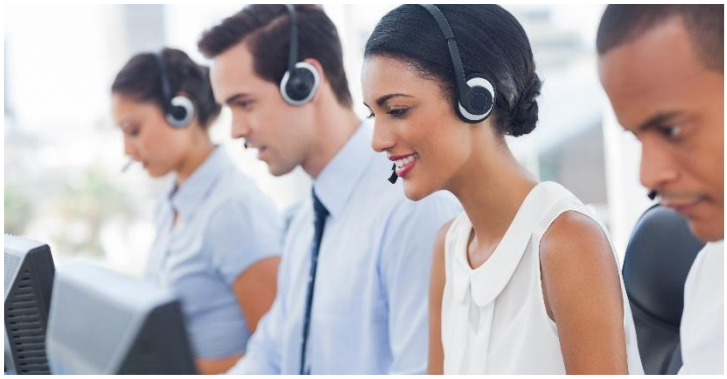
Important Benefit Contacts

COVERAGE	CARRIER	PHONE NUMBER	WEBSITE
Medical Insurance	AmeriHealth Administrators	(833) 803-4458	www.myahabenefits.com
Prescription Drug Coverage	Clearscript	(855) 816-6389	www.clearscript.org
Dental Insurance	Humana	(800) 448-6262	www.humana.com
Flexible Spending Account	Hello Further	(651) 662-5065	www.hellofurther.com
Life/AD&D Insurance	Principal	(800) 986-3343	www.principal.com
Voluntary Life Insurance	Principal	(800) 986-3343	www.principal.com
Long Term Disability	Principal	(800) 986-3343	www.principal.com
Short Term Disability	Formula Benefits	(651) 686-0108	www.formulabenefits.com/home.htm



St. Croix Chippewa Indians of Wisconsin strives to provide you and your family with a comprehensive and valuable benefits package. We want to make sure you're getting the most of our benefits – that's why we've 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 St. Croix Chippewa Indians of Wisconsin, so you can identify which offerings are best for you and your family.

If you have questions about any of the benefits mentioned in this guide, please don't hesitate to reach out to the Benefits Department.

IMPORTANT NOTICE

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 Insurance Department.

ELIGIBILITY, ENROLLMENT & CHANGES

Employee Eligibility

All full-time employees working 30 or more hours per week will be eligible for benefits.

As a new employee, you have 30 days from your eligibility date to enroll in benefits. Benefits will take effect the start of the month following 60 days of employment.

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.

How to Enroll

Are you ready to enroll? The first step is to review your current benefits. Did you move recently or get married? Verify all of your personal information and make any necessary changes.

Once all your information is up to date, it's time to make your benefit elections. The decisions you make during open enrollment can have a significant impact on your life and finances, so it is important to weigh your options carefully.

When to Enroll

Open enrollment dates are: mid-November through early December. Please watch for flyers with additional information.

How to Make Changes

Unless you experience a qualifying life event, you cannot make changes to your benefits until the next open enrollment period. Qualifying life events include things like:

- Marriage, divorce, legal separation or death of a spouse
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child or other qualified dependent
- Change in residence
- Change in employment status or a change in coverage under another employer-sponsored plan.

An election change must be made within 30 days of the qualifying event.

Employee Contributions Per Paycheck

Below is an overview of your employee contributions for 2024, per payroll (24 pay periods). These are subject to change. If you have questions or concerns, please speak with the Benefits Department.

Government & Commercial Health Plan	
Employee Only	$75.00 per paycheck
Family	$225.00 per paycheck

Working Tribal Health Plan (Members must be St. Croix enrolled)	
Employee Only	$47.50 per paycheck
Family	$72.50 per paycheck

High Deductible Health Plan	
Employee Only	$45.00 per paycheck
Family	$150.00 per paycheck

Dental	Preventive Plan	Buy-up Plan
Employee Only	No Cost – Paid for by St. Croix	$5.33 per paycheck
Employee + Spouse	$7.19 per paycheck	$16.97 per paycheck
Family	$19.80 per paycheck	$35.09 per paycheck

Vision	
Employee Only	No Cost – Paid for by St. Croix
Employee + Spouse	$3.43 per paycheck
Employee + Child(ren)	$3.08 per paycheck
Family	$6.81 per paycheck

Basic Life/AD&D	
Employee Only	No Cost – Paid for by St. Croix ($10.000 value)

Voluntary Life	
Employee and/or Dependents	If elected, this benefit is paid for by the employee. In addition to purchasing Voluntary Term Life Insurance for yourself, you can also purchase coverage for your spouse and dependent children. These are provided to you at group rates that you cannot get on your own! Please see detailed information in this guide.

Disability	Short-Term	Long-Term
Employee Only	No Cost – Paid for by St. Croix. *You are responsible for insurance premiums while out on leave status.	100% Voluntary

Health Insurance

AmeriHealth Administrators – 3 Plan Options

The St. Croix Chippewa Indians of Wisconsin Employee Insurance Plan is a partially self-funded group medical plan with AmeriHealth Administrators acting as the plan administrator. The Employee Insurance plan is a 3-Tiered network with different levels of co-pays and deductibles depending upon where services are provided. 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 the Benefits Department.

Government and Commercial Plan

Medical Plan Details	In-Network	Out-of-Network
Calendar Year Deductible • **Individual** • **Family**	 $750 $1,500	 $3,000 $6,000
Coinsurance • **Plan Pays** • **You Pay**	 80% 20%	 60% 40%
Annual Out-of-Pocket Max • **Individual** • **Family**	 $5,000 $10,000	 $12,700 $24,000
Medical Coverage	**In-Network**	**Out-of-Network**
Preventative Care	No Charge	No Charge
Primary Care Office Visit	$20 copay then 20% coinsurance	40% coinsurance
Specialist Office Visit	$20 copay then 20% coinsurance	40% Coinsurance
Urgent Care	No Charge	40% Coinsurance
Emergency Room	$125 copay, then 20% coinsurance	$125 copay, then 20% coinsurance
Hospitalization	20% Coinsurance	40% Coinsurance
Rx Drug Coverage	**In-Network**	**Out-of-Network**
Generic Drugs	$10 Copayment	No Coverage
Preferred brand drugs	$25 Copayment	
Non-preferred drugs	$40 Copayment	
Specialty Drugs	$10/$25/$40 Copayment	

Government & Commercial Health Plan	
Employee Only	$75.00 per paycheck
Family	$225.00 Per Paycheck

Health Insurance

AmeriHealth Administrators

This plan is only available for enrolled St. Croix tribal members.

Working Tribal Plan

Medical Plan Details	In-Network	Out-of-Network
Calendar Year Deductible • **Individual** • **Family**	No deductible	No deductible
Coinsurance • **Plan Pays** • **You Pay**	100%	Not Applicable
Annual Out-of-Pocket Max • **Individual** • **Family**	No Maximum Out-of-Pocket	Not Applicable
Medical Coverage	**In-Network**	**Out-of-Network**
Preventative Care	100%	100%
Primary Care Office Visit	100%	100%
Specialist Office Visit	100%	100%
Urgent Care	100%	100%
Emergency Room	100%	100%
Hospitalization	100%	100%
Rx Drug Coverage	**In-Network**	**Out-of-Network**
Generic Drugs	100%	No Coverage
Preferred brand drugs		
Non-preferred drugs		
Specialty drugs		

Medicare Like Rates (MLR)

Contract Health Eligible (federal enrolled or descendant Tribal member) employees and dependents will benefit from Medicare like Rate reimbursement on most hospital UB92 claims. If your hospitalization is eligible for Medicare like Rate reimbursement, any incurred hospital claims will be paid at 100% and there will not be deductible or coinsurance billed to you.

Working Tribal Health Plan	
Employee Only	$47.50 per paycheck
Family	$72.50 per paycheck

Health Insurance

AmeriHealth Administrators

High Deductible Health Plan

Medical Plan Details	In-Network	Out-of-Network
Calendar Year Deductible • **Individual** • **Family**	 $6,350 $12,700	 $10,000 $20,000
Coinsurance • **Plan Pays** • **You Pay**	 100% 0%	 60% 40%
Annual Out-of-Pocket Max • **Individual** • **Family**	 $6,350 $12,700	 $20,000 $40,000
Medical Coverage	**In-Network**	**Out-of-Network**
Preventative Care	No Charge	
Primary Care Office Visit	100% After Deductible	40% After Deductible
Specialist Office Visit	100% After Deductible	40% After Deductible
Urgent Care	100% After Deductible	40% After Deductible
Emergency Room	100% After Deductible	40% After Deductible
Hospitalization	100% After Deductible	40% After Deductible
Rx Drug Coverage	**In-Network**	**Out-of-Network**
Tier 1	100% After Deductible	No Coverage
Tier 2		
Tier 3		
Tier 4		

High Deductible Health Plan	
Employee Only	$45.00 per paycheck
Family	$150.00 per paycheck

Purchased/Referred Care (PRC)

Medical/dental care provided at an Indian Health Service (IHS) or tribal health care facility is called ***Direct Care****. The* ***Purchased/Referred Care (PRC)*** *Program at IHS is for medical/dental care provided away from an IHS or tribal health care facility. PRC is not an entitlement program and an IHS medical referral does not imply the care will be paid. If IHS is requested to pay, then a patient must meet the American Indian/Alaska Native tribal affiliation, residency requirements, notification requirements, medical priority, and use of alternate resources (including IHS facility).*

All American Indians should be aware of the following requirements each time he/she is referred or requests IHS to pay for medical care away from an IHS or tribal health care facility:

- Patient responsibility to comply with ALL PRC requirements
- PRC is not an entitlement program
- PRC Eligibility Requirements
- PRC Notification Requirements
- PRC Patient Process for Authorization for Payment Diagram
- Medical/Dental Priority of Care
- Use of Alternate Resource (Medicare, Medicaid, VA, Private Insurance, charity, etc.)
- Appeal Process for Denial of PRC care
- Patient Rights & Responsibilities
- Directory for an IHS or tribal health care facility near your location

Indian Health Service: The Federal Health Program for American Indians and Alaska Natives

There are two types of care that is covered by Purchased/Referred Care (PRC, formerly known as Contract Health Services) dollars for PRC eligible patients

1. **DIRECT**: All services provided/received by an Indian Health Service Facility
   - St. Croix Health Center
   - St. Croix Dental Center
2. **PRC**: All services provided outside an IHS Facility with a referral or properly reported

"Indian Health Services (IHS) is the payer of last resort for services provided under the CHS program and ***all alternate resources that are available for provision or payment of eligible medical services to the eligible tribal member must be used prior to CHS funds being expended."***

This means that if health insurance coverage is offered to PRC eligible tribal employees, then to be eligible for PRC dollars Health Insurance funding must first be utilized to pay for medical coverage

Learn more about IHS Purchased/Referred Care (PRC) program and view Frequently Asked Questions (FAQs) at www.ihs.gov/prc/

Understanding the Medical Plan

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.

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.

In-network Bill

Provider	Network	Bill	Insurance Company Payment, Explanation of Benefits	Patient
The patient receives treatment. The doctor then sends the bill to the insurance company.	Appropriate discount for using an in-network provider is applied.	The bill for services is presented to the insurance company. Payment responsibilities are calculated and divided between the patient and the insurance company.	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 company.	Patient pays doctor's office for copayments, deductibles and/or coinsurance that he or she is responsible for.

Out-of-network Bill

Provider	Bill	Insurance Company Payment, Explanation of Benefits	Patient
The patient receives treatment. The doctor then sends the bill to the insurance company.	The bill for services is presented to the insurance company. Payment responsibilities are calculated and divided between the patient and the insurance company.	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 company.	Patient pays doctor's office for copayments, deductibles and/or coinsurance that he or she is responsible for.

Flex Spending Account (FSA)

FSA's provide you with an important tax advantage that can help you pay health care and dependent care expenses on a pretax basis. By anticipating your family's health care and dependent care costs for the next year, you can actually lower your taxable income!

Health Care Reimbursement FSA

Through the company-sponsored plans, employees may choose to allocate funds on a pre-tax basis for payment of their portion of IRS approved expenses.

The current limit on salary reduction contributions to a Health FSA offered under a cafeteria plan is $3,200.

This limit will be indexed for cost-of-living adjustments in subsequent years. Some examples of eligible expenses include:
Hearing services, including hearing aids and batteries
Vision services, including contact lenses, contact lens solution, eye examinations and eyeglasses
Dental services and orthodontia
Chiropractic services

Dependent Care FSA

The Dependent Care FSA lets employees use pre-tax dollars toward qualified dependent care expenses such as caring for children under age 13 or caring for elders. The annual maximum amount you may contribute to the Dependent Care FSA is $5,000 (or $2,500 if married and filing separately) per calendar year.

Some examples of eligible expenses include:
The cost of child or adult dependent care
The cost for an individual to provide care either in or out of your house
Nursery schools and preschools (excluding kindergarten)

Health Savings Account

Employees who enroll in the St. Croix High Deductible Health Plan are eligible to utilize a Health Savings Account (HSA). All money in your HSA is yours to save for use on medical, dental, & vision expenses or for retirement.

Due to IRS regulations, Tribal Members and registered descendants are unable to enroll in a HSA when they have access to PRC Dollars.

Employees enrolled in the High Deductible Health Plan (HDHP) are eligible to utilize a Health Savings Account (HSA) administered by a bank or credit union of your choice. Money in your HSA is yours to save for use on medical, dental, & vision expenses or for retirement.

What Are the Benefits of an HSA?

- **It saves you money**. HDHPs have lower monthly premiums, meaning less money is being taken out of your paycheck.
- **It is portable**. The money in your HSA is carried over from year to year and is yours to keep, regardless of your employer.
- **It is a tax-saver**. HSA contributions are made with pre-tax dollars. Since your taxable income is decreased by your contributions, you'll pay less in taxes.

HSA Contribution Limits

The maximum amount that you can contribute to an HSA is $4,150 (individual) or $8,300 (family) in 2024. If you are age 55 or older, you may make an additional "catch-up" contribution of **$1,000**. You may change your contribution amount at any time throughout the year as long as you don't exceed the annual maximum.

HSA Case Study

Justin is a healthy 28-year-old single man who contributes $1,000 each year to his HSA. His plan's annual deductible is $1,500 for individual coverage. Here is a look at the first two years of Justin's HSA plan, assuming the use of in-network providers. This example only includes HSA contribution amounts and does not reflect any investment earnings.

Year 1		→	Year 2	
HSA Balance	$1,000		HSA Balance	$1,850
Total Expenses: **Prescription drugs: $150**	(-$150)		Total Expenses: Office visits: $100 Prescription drugs: $200 Preventive care services: $0 (covered by insurance)	(-$300)
HSA Rollover to Year 2	$850	→	HSA Rollover to Year 3	$1,550
Since Justin did not spend all of his HSA dollars, he did not need to pay any additional amounts out-of-pocket this year.			Once again, since Justin did not spend all of his HSA dollars, he did not need to pay any additional amounts out-of-pocket this year.	

Utilizing a Limited FSA & a HSA
You may not utilize the full Medical FSA if you elect an HSA.
A Limited FSA allows you to continue to contribute to an HSA. You maximize your savings and tax benefits by restricting your FSA reimbursement to only vision and dental expenses.

Employees that elect the High Deductible Health Plan (HDHP) must set up a Health Savings Account (HSA). Changes to HSA contribution elections can only be made during Open Enrollment.

Dental Insurance

Humana

St. Croix offers a preventive dental plan to all employees. You may add dependents by paying more. You may also buy up to a more robust dental plan by paying the difference between that better plan and the preventive one.

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

Dental Plan Details	Preventive Plan	Buy-up Plan
Calendar Year Deductible • **Individual** • **Family**	$50 $150	$50 $150
Annual Out-of-Pocket Max • **Individual** • **Family**	$1,000	$1,000
Orthodontia: Child Only (through age 18)	Not a covered service.	50% of covered ortho services up to $1,000 lifetime ortho maximum.
Coverages	**In-Network**	**In-Network**
Preventative Care	100%, deductible waived	100%, deductible waived
Basic Services	80%	80%
Major Services	0%	50%
Orthodontia Services (Child only, up to age 19)	N/A	$1,000 lifetime maximum

Both plans allow you to visit any dental provider you choose - however, you will get the best coverage when you choose a *Delta Dental PPO Provider.* By utilizing a Carrier PPO Provider, you can significantly reduce your out-of-pocket expenses, and make your Plan Maximums go farther.

Employee Cost per paycheck	Preventive Plan	Buy-up Plan
Employee Only	No Cost – Paid for by St. Croix	$5.33 per paycheck
Employee + Spouse	$7.19 per paycheck	$16.97 per paycheck
Family	$19.80 per paycheck	$35.09 per paycheck

Vision Insurance

Humana

For a complete list of your in-network and out-of-network benefits, please refer to your Vision Insurance Summary Plan Description, provided by the Benefits Department.

Vision Plan Details	In-Network	Out-of-Network
Exam Once every 12 months	$10 copay	Up to $30
Lenses Once every 12 months	$15 materials copay, $130 allowance	Not covered
Frames Once every 24 months	$15 materials copay, $130 allowance	Up to $65
Contact Lenses Once every 12 months; in lieu of lenses/frames glasses	$15 materials copay, $130 allowance	Up to $104

Employee Cost per paycheck	Preventive Plan
Employee Only	No Cost – Paid for by St. Croix
Employee + Spouse	$3.43 per paycheck
Employee + Children	$3.08 per paycheck
Family	$6.81 per paycheck

Basic Life/AD&D Insurance

Principal

Life insurance can help provide for your loved ones if something were to happen to you. St. Croix provides all eligible employees with **$10,000** of basic life and accidental death and dismemberment (AD&D) insurance.*

REMINDER: Even though all eligible employees are automatically enrolled in this coverage when eligible, it is important to update your beneficiaries and make sure they are accurate periodically. Having out of date beneficiaries listed will make it difficult to pay the benefit to the correct person in case it is ever needed.

Basic Life & AD&D Plan	
Coverage Amount	**Employee:** $10,000
Reduction Schedule	**65%** at age 65, **45%** at age 70, **30%** at age 75, **20%** at age 80+
Employee Cost	Paid for by St. Croix

HOW MUCH LIFE INSURANCE COVERAGE DO YOU NEED?

Depending on your personal situation, you may wish to purchase additional coverage that you can buy at affordable group rates.

Use this worksheet to estimate how much additional life insurance you need and see the details of the voluntary life on the following page.

When considering how much life insurance you need, it's important to think about your outstanding debt, ongoing expenses and the future plans of your family. Fill in the blanks to figure out how much life insurance you may wish to purchase.

Outstanding Debt – How much will be left for your family to pay?	
Mortgage balance	$ _____
Other debt (credit cards, loans, car payment)	$ _____
TOTAL (A)	$ _____ (A)
Ongoing Expenses – How much do your dependents need each year?	
Utilities (electric, phone, cable, internet)	$ _____
Medical costs, insurance	$ _____
Food, clothing, gasoline	$ _____
Saving contributions	$ _____
TOTAL (B)	$ _____ (B)
Future Plans – How much will loved ones need for the future?	
College	$ _____
Other (retirement, long term care)	$ _____
TOTAL (C)	$ _____ (C)
Grand Total (A+B+C)	$ _____
Subtract existing coverage	$ _____
Subtract company-paid life	$ _____
Consider this amount of life insurance	$ _____

**AD&D pays a benefit for loss of life or dismemberment resulting from a covered accidental bodily injury. Your beneficiary may receive up to 100% of the AD&D amount if you die as the result of a covered accidental injury. You may receive an accidental dismemberment benefit for losses of a hand, a foot, or the sight of an eye due to an accidental injury. See the policy for exact schedule of losses and benefits.*

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.*

Benefits may be reduced for employees over age 65 per ADEA.

Voluntary Life/AD&D Insurance

Principal

While St. Croix offers basic life insurance, some employees may want to purchase additional coverage. Think about your personal circumstances. Are you the sole provider for your household? What other expenses do you expect in the future (for example, college tuition for your child)? Depending on your needs, you may want to consider buying supplemental coverage.

With voluntary life insurance, you are responsible for paying the full cost of coverage through payroll deductions. You can purchase coverage for yourself or for your spouse in **$10,000 increments, up to a $100,000 maximum**.

REMINDER: If you are a new hire, this is your chance to receive Guaranteed Issue for yourself and your dependents. If you do not take advantage of this benefit at your initial enrollment but then choose to enroll at a later date, you will be subject to evidence of insurability (answer medical questions).

Voluntary Term Life & AD&D Plan	
Life/AD&D Benefit Amount	**Employee:** $10,000 increments, up to $100,000 maximum **Spouse:** $10,000 increments, up to $30,000 maximum **Dependent child(ren) (age at death):** • Live birth but less than 14 days old: $1,000 • 14 days+: $10,000
Guarantee Issue Amount*	**Employee:** $100,000 **Spouse:** $30,000 **Child(ren):** $1,000 or $10,000, dependent on age
Reduction Schedule	**65%** at age 65, **40%** at age 70, **25%** at age 75+

Please see the Benefits Team for current rates.

Definition of "Eligible Dependents"

- **Spouse** – eligibility may terminate at Spouse age 70.
- **Child** – eligibility terminates earliest of age 26, married, or employed full time, or no longer a Full Time Student. Terms may vary for children with special needs.

Important – Please Read!

- Dependents may have a delayed effective date based on his/her medical status at time of enrollment. Please refer to the policy certificate or HR for more details.
- Please update your beneficiaries periodically! If you do not update your beneficiaries, it will make it harder for the right person to receive your benefit, if ever needed.
- It is the responsibility of the employee to ensure dependents are eligible for coverage under these policies. Please refer to the policy certificate or HR for more information.

*** If you enroll when first offered, you receive up to the listed amount without having to answer medical questions**

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.* ***Benefits may be reduced for employees over age 65 per ADEA.***

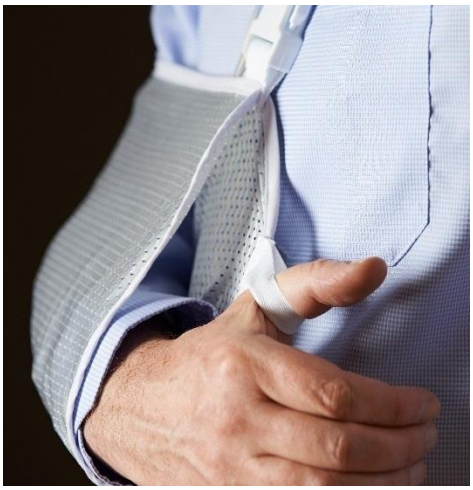
Short-Term Disability

Formula Benefits

Short-Term Disability Insurance can pay you a percentage of your gross weekly earnings if you are unable to work for a few weeks or months due to an illness or injury—or childbirth. It can help you cover your expenses and protect your finances at a time when you're not getting a paycheck and have extra medical bills.

Short-Term Disability coverage is effective the first day of the following month after 90 days of employment. Coverage will provide you with 60% of your weekly wage during periods of disability, up to $500 per week. Benefit payments begin on the 1st day of disability if disability is due to an accidental injury and on the 8th day of disability if disability is due to an illness or elective procedure. The maximum benefit period is 12 weeks. This is an employer paid benefit and participation in the Return to Work program is mandatory.

Short-Term Disability	
Weekly Benefit Amount	60% of weekly gross wages, up to $500 per week
Waiting Period	Eligible 1st day for injury or 8th day of illness or elective procedure
Benefit Duration	Up to 12 weeks
Employee Cost*	Paid for by St. Croix *You are responsible for insurance premiums while out on leave status.



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

Principal

Long Term Disability Insurance can pay you a percentage of your gross monthly earnings if you become ill or injured and can't work for an extended period. It can help you pay your bills and protect your finances at a time when you have extra medical costs but don't get a paycheck.

The length of time you can receive benefits is based on your age when you become disabled. Coverage is effective once Short-Term Disability benefits are exhausted and pays at 60% of your gross wages. Premiums are based on age and salary. It is offered after-tax and you may enroll or drop at the end of the payroll month during the year. The maximum benefit is six months for your current job, two years for any other job and supplemented to SSI up to age 65 if still disabled.

Long-Term Disability	
Monthly Benefit Amount	60% of monthly gross wages, up to $3,000 per month
Benefit Period	*The benefit period varies. See your summary plan description for specifics.*
Benefit Duration	24 Months Own Occupation
Elimination Period	90 days
Pre-Existing Condition Limitations	The pre-existing condition exclusion applies if the insured received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to his or her effective date of coverage; and the disability begins in the first 12 months after his or her effective date of coverage
Employee Cost	100% voluntary, based on age and salary – see the Benefits Team for current 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 Life/AD&D Plan Features

Principal

The St. Croix Benefits Department does not provide additional guidance on the below mentioned items. All inquiries and questions about these products can be directed to Principal Life Insurance Company at (800) 986-3343.

Funeral Planning

The first nationwide funeral planning and concierge service. Provides employees with free access to online planning tools, family support and 24/7 advisor assistance when they are dealing with a loss, and need it most.

EAP (Employee Assistance Program)

With EAP, employees have access to resources to help handle life's every day and not so everyday issues, anxiety, addiction, aging parents to care for. EAP offers a range of services to help employees live their best lives including 3 face-to-face visits with a licensed mental health practitioner, online assistance with eldercare, childcare and other family life resources, and 24/7 phone consultation with licensed mental health professionals.

Estate Guidance

Online will preparation with attorney support. Allows employees to create a simple will from the convenience of their own home. This service also provides access to licensed attorneys for support and questions.

Beneficiary Assist

Professional support for employees that have experienced a loss or terminal illness. Includes unlimited 24/7 phone access to advisors that can help with legal advice, financial planning, and emotional counseling. This service also includes five face-to-face sessions with a professional advisor.

Travel Assistance

Travel concierge service that provides Emergency Medical Assistance, Pre-trip information and Emergency Personal Services for employees traveling more than 100 miles away from home; for 90 days or less.

Identity theft Protection

Offers employees access to Prevention Services, Detection Services and Resolution and Guidance Services when they experience an Identity Theft.

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 Company Benefits

Family Medical Leave (FMLA)

Employees must meet all of the following conditions: (1) must have worked for St. Croix 12 months or 52 weeks, (2) must have worked at least 1,250 hours during the 12 month period immediately before the date when the leave is requested to commence and (3) must work in a worksite where 50 or more employees are employed by St. Croix within 75 miles of that office or worksite. Please review St Croix Chippewa Family and Medical Leave Act Policies in place for more details.

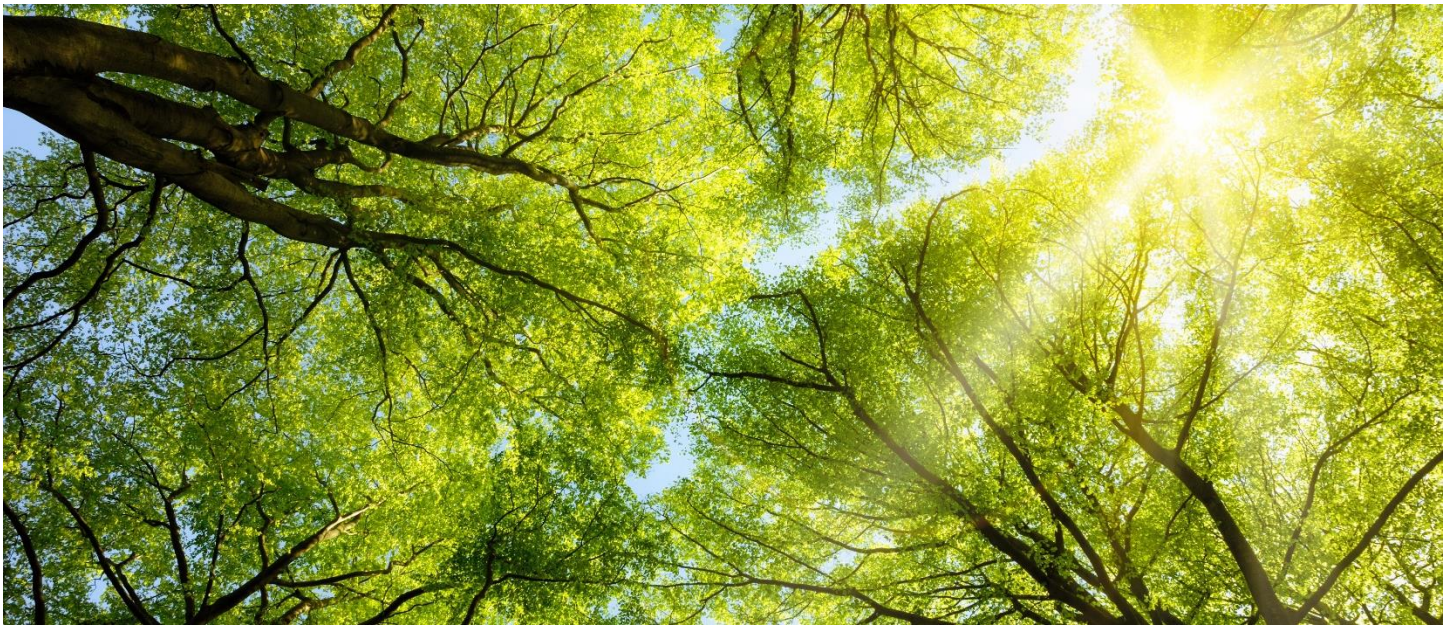
Worker's Compensation

All employees of the St. Croix Chippewa Indians of Wisconsin are covered while in the course and scope of employment, whether on or off Tribal lands.

What are the benefits:

- We will pay 2/3 of lost wages up to a $700 maximum, subject to a three-scheduled workday waiting period. If seven or more scheduled workdays are lost, the waiting period is waived.
- Medical treatment expenses, including transportation and other reasonable expenses.
- Rehabilitation services if necessary.
- Compensation for permanent disability.
- Cost of medicines and supplies, equipment of a therapeutic nature, mileage and other related expenses necessary to obtain medical treatment, except the cost of child care.
- Death benefits for surviving dependents or beneficiaries.

Please review the full summary plan documents for a list of your exclusions and limitations.



401(K) & Roth Savings Program

Sentinel Group

As of January 1, 2024, there will be a matching contribution of 50% of employee's elected contribution, up to 6%.

Eligibility

In order to qualify for the match, you ….

- Must have been employed for 1 year and 1000 hours of service.
- If you are already participating and eligible for the match based on your hire date- it will begin automatically for you.
- Vesting is based on a 5-year schedule (20% per year)

An employee can start participating when they are Benefit Eligible – employees can choose between a traditional 401(k) plan and Roth Savings. The option is there for a flat dollar amount or a percentage. Employees must be at least 18 years of age.

About 401(k) and Roth Savings Plans

The main difference between a traditional 401(k) and a Roth 401(k) is when the money is taxed. With a traditional 401(k) plan, an employee's contributions are made on a pre-tax basis, and the employee is taxed upon withdrawal from the plan during retirement.

Conversely, an employee's Roth 401(k) contributions are made after taxes have been taken out, and withdrawals in retirement are tax-free. An employee may want to consider what tax bracket he or she is in now and compare it to the tax bracket he or she expects to be in during retirement.

A Roth 401(k) may be the best choice if an employee is just beginning his or her career and anticipates higher earnings later in life. Since the Roth 401(k) involves paying taxes now rather than later, this individual would be getting more money at retirement because there are fewer taxes taken out now—due to having a lower income—than there would be later on when he or she is earning more money.

Roth 401(k) plans might also be a good choice for higher-paid employees who are not eligible for Roth IRAs and other similar plans. The tax-free withdrawals would help highly paid employees manage their taxes in retirement.

For workers who are closer to retirement, Roth 401(k)s may not be as appealing. Since an individual will likely be in a higher tax bracket when contributing to the account than when he or she is retired and decides to withdraw from the account, the individual may prefer to pay taxes when he or she retires and is in a lower tax bracket.

Contacts

Carrier	Website	Direct Contact	Phone	Email
Record Keeper & Benefit Plan Administrator				
Sentinel Group	www.sentinelgroup.com	Dennis Davis	505-998-3294	Dennis.Davis@sentinelgroup.com
Plan Advisors				
NFP Retirement Inc.	www.nfp.com	Justin Goldstein	608-416-4397	justin.goldstein@nfp.com

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.*

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.
Example: John's second surgery occurs in the same plan year as his first surgery and costs a total of $3,200. Because he has only paid $800 toward his $1,000 annual deductible, John will be responsible for the first $200 of the second surgery. After that, he has met his deductible and his carrier will cover 80 percent of the remaining cost, for a total of $2,400. John will still be responsible for 20 percent, or $600, of the remaining cost. The total John must pay for his second surgery is $800.

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.

St. Croix Chippewa Indians of Wisconsin: Important Disclosures & Notices

Michelle's Law Notice

If the Plan provides for dependent coverage that is based on a dependent's full-time student status, then this Michelle's Law Notice applies. 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 a Leave of Absence

Your health benefits may be protected and maintained during a leave of absence, such as a leave qualifying under the Family Medical Leave Act. Other leaves of absence may, however, render you ineligible to participate in the health plan. If coverage is lost due to a leave of absence, you may be eligible to continue coverage under COBRA. Similarly, if you become ineligible for health benefits due to a leave of absence for military reasons, you may be eligible to continue that coverage under USERRA. Please contact your Human Resources Department or your manager for more information regarding what benefits are protected and maintained during a leave of absence and for more information about FMLA, COBRA and USERRA. ❖

Premium Assistance under Medicaid and The Children's Health Insurance Program (CHIP)

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, 2022. 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:
https://dhss.alaska.gov/dpa/Pages/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
Fax: 916-440-5676
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
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: (678) 564-1162, Press 2

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
Kentucky 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/masshealth/pa
Phone: 1-800-862-4840
TTY: (617) 886-8102

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
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

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

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll-free number for the HIPP program:
1-800-852-3345, ext. 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
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/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 and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone:
1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
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, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565 ❖

Patient Protection Notice

If the St. Croix Chippewa Indians of Wisconsin generally requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, you will be able to designate a new provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Human Resources. ❖

Women's Health and Cancer Rights Act of 1998

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. ❖

Newborns' and Mothers' Health Protection Act

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 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 no later than the first day of the first month beginning after the date the plan receives a timely request for enrollment.

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

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 St. Croix Chippewa Indians of Wisconsin Group Medical Plan (the "Plan"), which includes medical, dental and flex spending coverages offered under the St. Croix Chippewa Indians of Wisconsin 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 St. Croix Chippewa Indians of Wisconsin 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
St. Croix Chippewa Indians of Wisconsin is required to 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 St. Croix Chippewa Indians of Wisconsin, 24663 Angeline Avenue, Webster WI 54893 , 715-349-2195 .

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 St. Croix Chippewa Indians of Wisconsin, 24663 Angeline Avenue, Webster WI 54893 , 715-349-2195 . 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 St. Croix Chippewa Indians of Wisconsin, 24663 Angeline Avenue, Webster WI 54893, 715-349-2195. 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 St. Croix Chippewa Indians of Wisconsin, 24663 Angeline Avenue, Webster WI 54893 , 715-349-2195 . 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 St. Croix Chippewa Indians of Wisconsin, 24663 Angeline Avenue, Webster WI 54893, 715-349-2195. 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 St. Croix Chippewa Indians of Wisconsin, 24663 Angeline Avenue, Webster WI 54893 , 715-349-2195 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 St. Croix Chippewa Indians of Wisconsin, 24663 Angeline Avenue, Webster WI 54893 , 715-349-2195 . 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 St. Croix Chippewa Indians of Wisconsin 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 St. Croix Chippewa Indians of Wisconsin 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. St. Croix Chippewa Indians of Wisconsin has determined that the prescription drug coverage offered by the St. Croix Chippewa Indians of Wisconsin 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 St. Croix Chippewa Indians of Wisconsin coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current St. Croix Chippewa Indians of Wisconsin 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 St. Croix Chippewa Indians of Wisconsin 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 St. Croix Chippewa Indians of Wisconsin 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: 10/2/2024
Name of Entity/Sender: St. Croix Chippewa Indians of Wisconsin
Contact--Position/Office: Human Resources
Address: 24663 Angeline Avenue, Webster WI 54893
Phone Number: 715-349-2195