St. Croix Chippewa Indians of Wisconsin

2026 | Behold our Heritage. Share our Future.

Benefits Guide

Inside

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 your department's Insurance Team Office.

Welcome

We understand that your life extends beyond the workplace. That's why we offer a variety of benefits to help you be an advocate of your health and well-being. Our goal is to provide choices for you and your family to be appropriately covered through all stages of life.

Current Employees

Open enrollment, which usually occurs annually in November or December, is your once-a-year opportunity to adjust benefit coverages and update any dependents and beneficiaries. 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.

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, you need to enroll each year in this**.

New Hires

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.

Learn More on our Benefits Microsite!

Scan QR code or visit
https://www.cbmicrosite.com/stcroixchippewaindians/

How to Make Changes

Unless you experience a qualifying life event, you cannot make changes to your benefits until the next open enrollment period. An election change must be made within 30 days of the qualifying event. Examples include:

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

Medicare Part D Notice: If you or your dependents are on Medicare or will be eligible within 12 months, federal law offers more prescription drug coverage options. Refer to pages 31-34 for details.

Contacts

St. Croix Benefits Contact		
Kelly Bertuleit	Benefits Director	715-349-2195 ext. 5306
Heidi Rand	Benefit Specialist	715-349-2195 ext. 5272
Brittany Whittier	Benefits Specialist	800-238-8946 ext. 2616
Cheri LaBlanc	Benefit Specialist	715-986-4777 ext. 3116
Debbie Tucker	Workers Compensation Specialist	715-986-4777 ext. 3038

Coverage	Carrier	Phone Number	Website/Email
Medical Insurance	UMR	(866) 494-4502	www.UMR.com
Prescription Drug Coverage	ClearScript	(855) 816-6389	www.clearscript.org
Dental Insurance	Humana	(866) 427-7478	www.humana.com
Vision Insurance	Humana	(877) 398-2980	www.humana.com
Flexible Spending Account	HealthEquity	(844) 351-6856	www.healthequity.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	UMR	(866) 494-4502	www.UMR.com

Eligibility

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.

* **IMPORTANT**: Some benefits may require employees to be actively at work at the time benefits become effective. Please review policy documents, or contact HR, for additional information.

Dependent Eligibility

If you are enrolled in coverage, you may also have the option to enroll your dependents in coverage.

Definition of "Eligible Dependents"

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: November 17th - December 5th. 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

Below is an overview of your employee contributions for 2026, 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
Employee + 1	$150.00 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	$3.26 per paycheck
Employee + Child(ren)	$2.93 per paycheck
Family	$6.47 per paycheck

Basic Life/AD&D	
Employee Only	Provided by St. Croix

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	Provided by St. Croix. *You are responsible for insurance premiums while out on leave status.	100% Voluntary

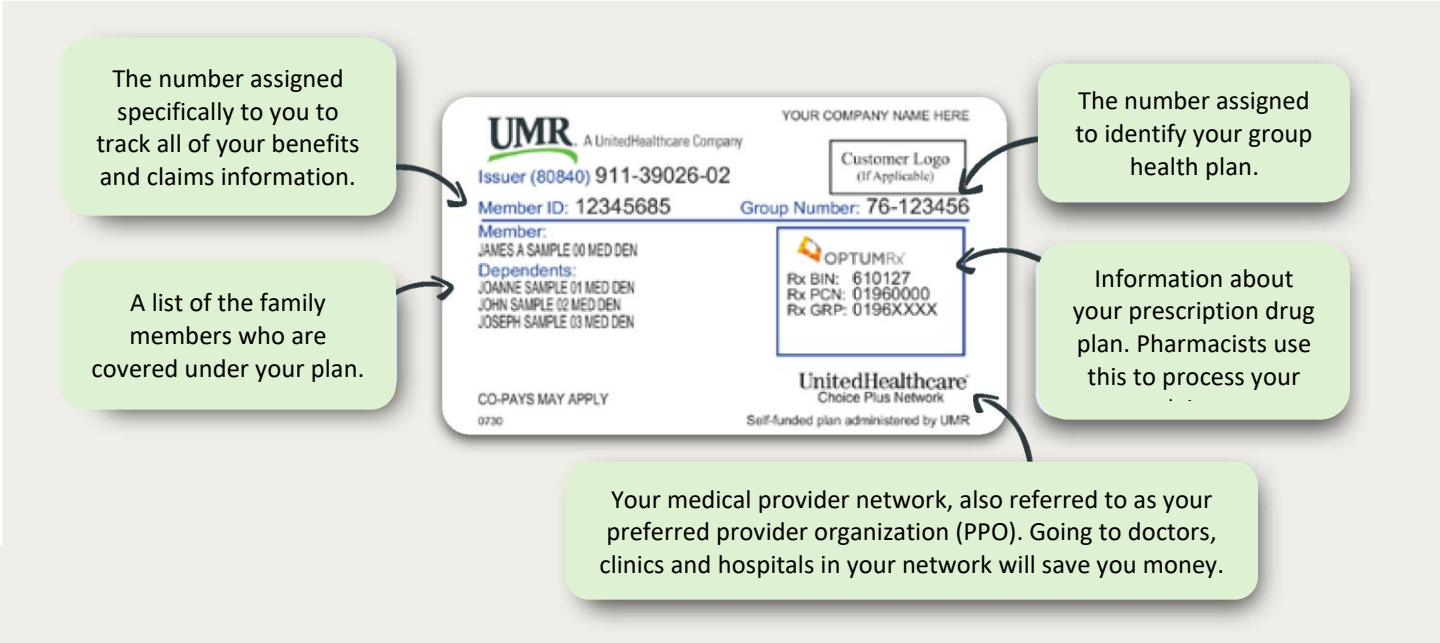
Understand Your UMR ID Card

After you've completed enrollment, St. Croix has approved it and after any waiting period has passed, your benefits will be effective. Your UMR ID Card will be on its way to you soon.

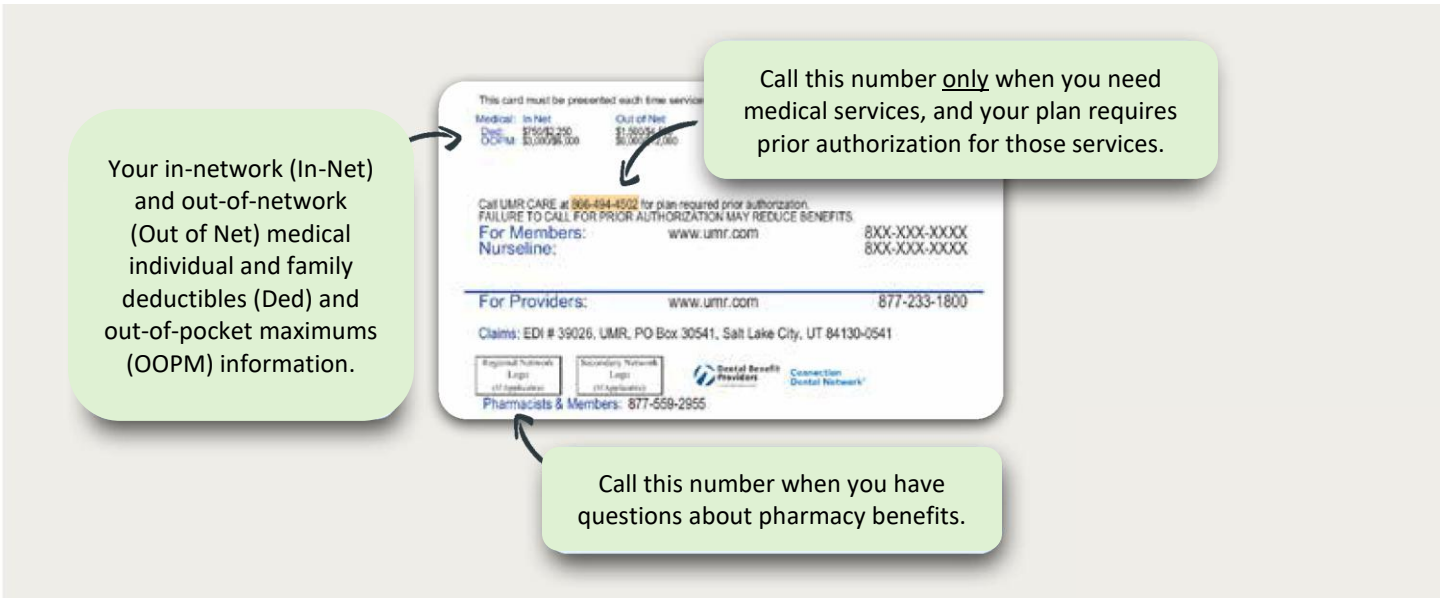
The card shows UMR as your health plan administrator. Keep it in your wallet and carry it with you.

What does the stuff on your ID card really mean?

Here's a sample of what you might see.



Look for important contact information, including the customer service phone number to call for answers to claims or benefit questions. You can also go to www.umr.com to check your benefits, claim status, accumulators, and eligibility.



UMR Portal Resources

Make **umr.com** your first stop

You want managing your health care to be fast and easy, right? You got it. At **www.umr.com,** you'll find everything you want to know – and need to do – as soon as you log in. No hassles. No waiting. Just the answers you're looking for anytime, night or day!

Log in now to:

- View **Things to do**, your personalized benefits to-do list
- Check your benefits and see what's covered
- Look up what you owe and how much you've paid
- Find a doctor in your network
- Learn about medical conditions and your treatment options
- Access tools and trusted resources to help you live a healthier life

Logging in is easy

Ready to pop in and take our site for a spin? Visit **www.umr.com** on your desktop or tablet device. If you already have an account, simply click the **Login/Register** button in the upper-right corner.

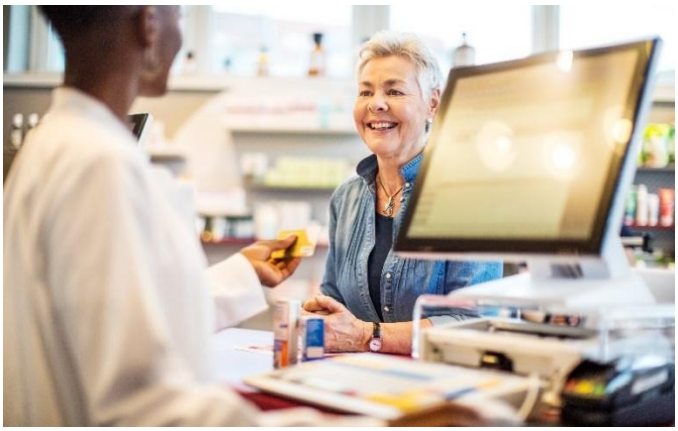
If it's your first time visiting us, click the **Login/Register** button in the upper-right corner to open an account. Make sure you have your ID card handy and follow the steps to get started.

Health cost estimator

The next time you're in the market for a new doctor or are wondering how much you'll pay for a possible medical procedure, visit **www.umr.com** first.

Your online services make it easy to look up UnitedHealthcare network providers and health care facilities and find cost estimates for different services – all in one place.

You'll get the information you need to make the right choices for you and your family and know what to expect before making an appointment



Find an in-network provider

With **www.umr.com**, you have anytime access to a searchable directory of UnitedHealthcare network providers in your area. Choosing a doctor or facility in the network ensures your benefits are paid at the highest level, so you can expect to pay less out of your own pocket. And when you go to a network provider for preventive services, there's typically no cost to you.

You can narrow your search to primary care providers or look up physicians by specialty. Then select a physician from your search results to learn more about where they went to school, where they practice and how to schedule an appointment.

Order replacement ID cards

Click **ID card** from **myMenu** to see a copy of your card. With a couple more clicks you can have a new card mailed to your home. Can't wait for the mailman? Print a temporary copy from our desktop site. Or, use your smart phone to view your ID card or fax a copy to your doctor's office.

Know Where to Go for Care

Where Should I Go for Care?
www.cbmicrosite.com/video/knowwheretogo

Keeping your health care costs in check could be as simple as making the right choice when you need medical care. When you have an illness or suffer an injury, you understandably want to feel better fast, but making the wrong choice about where to receive care can cost you.

The average outpatient emergency room (ER) visit costs $1,917, according to the Health Care Cost Institute. This means that if you head to the ER when you don't really need emergency care, your wallet is going to feel the pain.

Where Should I Go?

Sometimes, it can be difficult to know where to draw the line when it comes to choosing if you should go to the ER, urgent care, or your primary doctor. Here are a few guidelines to help you know where to go next time you're sick or injured.

Emergency Room ($$$$)

A visit to the ER is the most expensive type of outpatient care and should only occur if there is a true emergency, or a life-threatening illness or injury. Examples of conditions that should be addressed in the ER include, but aren't limited to:

Chest pain
Uncontrollable bleeding
Shortness of breath
Poisoning

Urgent Care ($$$)

Urgent care centers handle non-emergency conditions that require immediate attention—those for which delaying treatment could cause serious problems or discomfort. Urgent care visits are less expensive than ER visits but are typically more expensive than a visit to your primary care doctor. These conditions can usually be treated in urgent care centers:

Sprains
Ear infections
High fevers

Doctor's Office ($$)

For most non-emergency illnesses or injuries, the best choice for medical care may be a visit to your primary care physician. Your regular doctor knows you best, has your medical history, and has the expertise to diagnose and treat most conditions. In addition, going to the doctor's office is usually the most cost-effective option.

Health Insurance

UMR – 3 Plan Options

The St. Croix Chippewa Indians of Wisconsin Employee Insurance Plan is a partially self-funded group medical plan with UMR acting as the plan administrator. You will get the best coverage when you choose an in-network provider.

Reminder: Be sure to find a provider online at www.umr.com . From there, you have access to a searchable directory of UnitedHealthcare network providers in your area. Choosing a doctor or facility in the network ensures your benefits are paid at the highest level, so you can expect to pay less out of your own pocket.

Government and Commercial Plan

Medical Plan Details	In-Network	Out-of-Network
Calendar Year Deductible **Individual** **Family**	 $500 $1,000	 $3,000 $6,000
Coinsurance **Plan Pays** **You Pay**	 80% 20%	 60% 40%
Annual Out-of-Pocket Max **Individual** **Family**	 $4,000 $8,000	 $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
Employee + 1	$150 per paycheck
Family	$225.00 Per Paycheck

Please review the full plan documents for details. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

Health Insurance

UMR

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)

St. Croix's Tribal Member Health Plan is taking advantage of Medicare-Like-Rate (MLR) for Tribal Members enrolled in UMR Health coverage. In order for claims to paid at 100% with NO patient responsibility, please request a referral from PRC and present your ID Card to your provider.

To take advantage of this program, St. Croix has partnered with UMR to price facility and professional claims with Medicare-Like-Rates for Tribal Members that are also Tribal Employees enrolled in the Employee Health Plan (tribal members/tribal employees). An eligible tribal member/tribal employee is a member that is eligible for Purchased/Referred Care services and has approval from PRC for designated hospital services.

This Medicare-Like Rate applies to all levels of care, furnished by a Medicare-participating hospital for services that are authorized by Purchased/Referred Care (PRC). This includes care provided as inpatient, outpatient, or skilled nursing facility care. All eligible hospitals must accept the MLR as payment in full, with no patient balance. Eligible hospitals are prohibited from refusing to provide services to an individual on the basis that payment is subject to Medicare-Like-Rates. If the hospital does not participate with Medicare, then the Health Plan will process the claim in accordance with the plan as if MLR was not in place.

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

Health Insurance

UMR

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/

Telemedicine

Teladoc

Available to employees enrolled in any of the St. Croix **medical plans**.

Telemedicine can be a great alternative to visiting your normal doctor or an urgent care, when you are suffering from one of many common, non-emergency medical conditions. Using your computer, tablet, or smartphone device, you can conveniently access to U.S. board-certified doctors and licensed professionals from the comfort of your home or wherever you happen to be.

In some cases, doctors can write a prescription to a local pharmacy near you.[1]

When can I use telemedicine?

- When you need care now.
- If you're considering the ER or urgent care center for a non-emergency issue.
- On vacation, on a business trip, or away from home.
- For short-term prescription refills.

Set up your account or log in to schedule a visit!

1. Visit www.teladochealth.com
2. Call 1-800-835-2363
3. Download the Teladoc App

Need Care Now?

General Medicine:

Need care for non-urgent and common conditions? Get same-day appointments with a certified clinician from wherever you are. Our clinicians diagnose, treat and even prescribe medicine if needed. **Examples include:** Allergies, Rashes, Bronchitis, Flu, COVID-19, Sinus Infections, Pink eye and more.

Mental Health:

Have real conversations and see progress with a therapist or psychiatrist of your choice. Available 7 days a week from the privacy of your own home. **Examples Include:** Anxiety, Depression, Sleep Issues, Relationship Conflicts, PTSD, Trauma, Medication Management and more.

Dermatology:

Dealing with a skin issue? Start an online skin review with a dermatologist by uploading images and details of your concern. Get a treatment plan and prescription if needed in 24 hours or less. **Examples Include:** Acne, Eczema, Psoriasis, Sin Infections, Rosacea and More.

[1] Prescription services may not be available in all states.

Flexible Spending Account

HealthEquity

*Available to employees enrolled in the **Government & Commercial medical plan or the Working Tribal plan**.*

The company offers you two different FSA options: a **Medical Reimbursement Account** and a **Dependent Care Reimbursement Account**. By using these accounts, you can save money and bring home more of your income by paying for medical care and dependent care expenses using PRE-TAX dollars from your payroll.

Eligible Expenses	**Medical:** http://www.irs.gov/publications/p502/ **Dependent Care:** http://www.irs.gov/publications/p503/

Health FSA

Pay for eligible medical, dental, vision, and prescription expenses, such as:

- Deductibles
- Copays
- Coinsurance
- Other health-related expense

2026 annual contribution limit	**$3,400 / IRS maximum**
Rollover	$680 / IRS maximum

Grace Period:
The period specified in the Summary, and not exceeding 2 ½ months, immediately following a Plan Year. Eligible Expenses incurred during a Grace Period may be reimbursed from the Carryover Amount from the prior Plan Year.
A Participant's Carryover Amount, if any, will be available to reimburse Eligible Expenses incurred prior to the end of the Grace Period. Expenses incurred during the Grace Period will first be reimbursed from the Carryover Amount and then from contributions for the current Plan Year.
Any amount remaining in a Participant's Account at the end of the Grace Period will be forfeited in accordance with the manner described in this Grace Period section.

Your eligibility for an FSA may be misrepresented if you and/or your spouse currently utilize an HSA. Check with the Human Resources to learn more.

Is a Health FSA Right for You?
www.cbmicrosite.com/video/healthfsa

Dependent Care FSA

Set aside tax-free money to care for children under age 13 or an elderly, dependent parent who is unable to care for themselves. Cover care expenses while you work, such as:

- Preschool
- Summer day camp
- Before and after school programs
- Elder care

2026 annual contribution limit	Married (Filing separately)	$3,750
	Single/Married (Filing jointly)	$7,500

Health Savings Account

Open at the financial institution of your choice

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.

Is an HSA Right for You?
www.cbmicrosite.com/video/hsa

HSA

Pay for eligible medical, dental, vision, and prescription expenses, such as:

- Deductibles
- Coinsurance
- Other health-related expenses

2026 annual contribution limit	Individual	$4,400 / IRS maximum
	Family	$8,750 / IRS maximum
	Catch-up contribution (Age 55 or older)	$1,000

Your eligibility for an HSA may be misrepresented if you and/or your spouse currently utilize an FSA. Check with the plan administrator or Human Resources to learn more.

Visit www.irs.gov and search for IRS Publication 502 to learn more about eligible expenses.

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 $1,600 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 visit: $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 his HSA dollars in year 1, the remaining funds roll over.			Once again Justin did not spend all his HSA dollars, so they roll over to the next year.	

Dental

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	Preventive Plan	Buy Up Plan
	In-Network	In-Network
Annual Deductible	$50 per individual $150 per family	$50 per individual $150 per family
Annual Benefit Maximum	$1,000	$1,000
Lifetime Orthodontia Maximum	Not covered	50% of covered ortho services up to $1,000 lifetime ortho max.
Plan Pays		
Preventive Care (Deductible waived)	100%, deductible waived	100%, deductible waived
Basic	80%	80%
Major	0%	50%
Orthodontia	N/A	$1,000 lifetime maximum

Employee Cost Per Paycheck	Preventive Plan	Buy Up Plan
Employee Only	No cost- Paid 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

Locate an in-network provider near you at www.humana.com or call (866) 427-7478.

Please review the full plan documents for details including out-of-network coverage. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

Vision

Humana

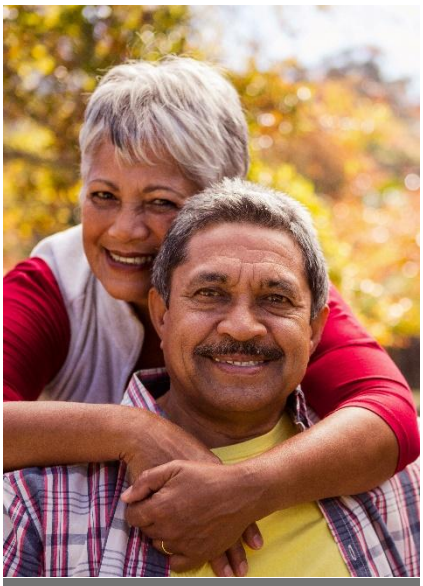
Driving to work, reading a news article and watching TV are all activities you likely perform every day. Your ability to do all of these activities, though, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems.

Vision	St. Croix Humana Vision Plan	
	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	
Employee Only	No Cost – Paid by St. Croix
Employee + Spouse	$3.26 per paycheck
Employee + Children	$2.93 per paycheck
Family	$6.47 per paycheck

Locate an in-network provider near you at www.humana.com or call (877) 398-2980.

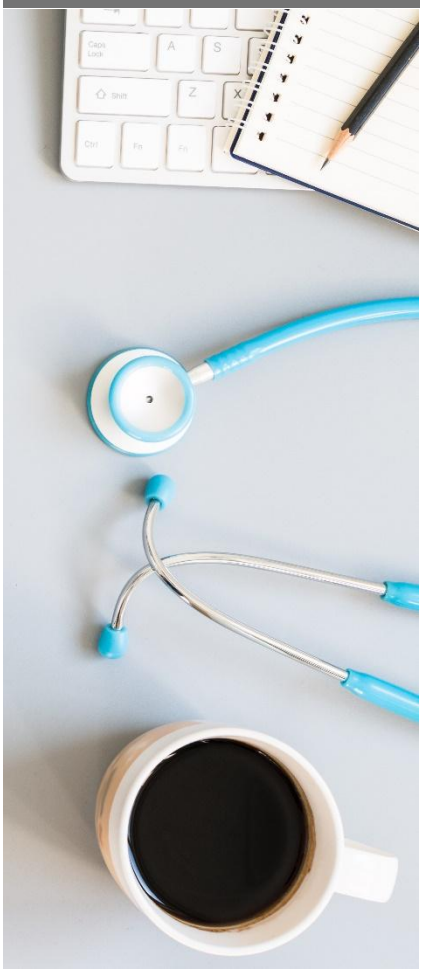
Please review the full plan documents for details including out-of-network coverage. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.



Schedule a consultation today!

(877) 837-4196

www.fedlogicgroup.com
services@fedlogicgroup.com



State & Federal Benefits Assistance

FEDlogic

We have partnered with FEDlogic to provide state and federal benefits information and advocacy to you and your household members.

The service is free, unlimited, and confidential!

Get help navigating resources that you may be eligible for, such as:

- Medicare
- Medicaid
- Disability
- Social Security Retirement
- Child Benefits
- Widow Benefits
- Veterans Benefits
- Supplemental Security Income (SSI)
- Healthcare.gov (COBRA alternatives)
- End Stage Renal Disease
- ALS (Lou Gehrig's Disease)
- Cancer or Terminal Illness

Here's how it works:

1. **Make a phone consultation appointment.**
   Call to schedule time with a federal and state benefits expert. Invite your family to join. Calls typically last an hour.
2. **Tell us your story, ask questions, and learn.**
   Experts will listen to your story and understand your needs, then empower you with unbiased information so you can make the best decisions for your situation.
3. **If qualified, get enrolled.**
   Once you feel confident with the information, experts will walk you through the application and approval process.
4. **Enjoy peace of mind.**
   Now you know you have access to assistance programs created for situations like this.

Life/AD&D

Principal

St. Croix provides all eligible employees with $10,000 of basic life and accidental death and dismemberment (AD&D) insurance.

Life insurance protects your loved ones financially in the event of your death. Accidental death and dismemberment (AD&D) provides an additional benefit if you die or experience other covered catastrophic loss due to a covered accident.

Basic Life/AD&D	
Benefit Amount	**Employee:** $10,000
Reduction Schedule	65% at age 65, 45% at age 70, 30% at age 75, 20% at age 80+
Benefit Cost	Provided by St. Croix!

Voluntary Term Life/AD&D	
Benefit Amount	**Employee:** Up to $100,000 maximum **Spouse:** Up to $30,000 maximum **Child(ren) (age at death):** - Live birth but less than 14 days old: $1,000 - 14 days+: $10,000
Benefit Cost	To view your personalized rates please see the Benefits Team.
Reduction Schedule	65% at age 65, 40% at age 70, 25% at age 75+

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

Actively-At-Work Requirement:
New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-At-Work/eligible status.

Definition of "Eligible Dependents"
It is the responsibility of the employee to ensure dependents are eligible for coverage under these policies.

- **Spouse:** Eligibility may reduce at Spouse age 65.
- **Child:** Eligibility terminates earliest of age 26. Terms may vary for children with special needs.

Please refer to the policy certificate or HR for more information.

Remember to update your beneficiaries.

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.

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

Short-Term Disability

UMR

If you become disabled due to a covered injury or illness, disability income benefits may provide a partial replacement of lost income. 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	
Benefit Amount	Replaces 60% of earnings, up to $500 per week
Benefit Begins	Injury: Eligible 1st day Illness/Elective Procedure: After 8 days
Employee Cost	Provided by St. Croix! You are responsible for insurance premiums while out on leave status.

NOTE: Short-term disability excludes work-related injury or illness.

Pre-Existing Condition Limitations:
If you file a claim within the exclusion period following your plan effective date, the carrier will review to determine if the condition existed during the look back period. If so, benefits may be denied.

Actively-At-Work Requirement:
New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-At-Work/eligible status.

Statutory Benefits Offset:
Your short-term disability benefit will be reduced by benefits from State Disability/Paid Family & Medical Leave for which you may be eligible.

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

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	
Benefit Amount	Replaces 60% of earnings, up to $3,000 per month
Benefit Begins	After a period of 90 days
Benefit Duration	24 Months (Own Occupation)

Long-Term Disability Cost	100% voluntary, based on age and salary – see the Benefits Team for current rates.

Pre-Existing Condition Limitations:
If you file a claim within the exclusion period following your plan effective date, the carrier will review to determine if the condition existed during the look back period. If so, benefits may be denied. **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**

Actively-At-Work Requirement:
New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-At-Work/eligible status.

Please review the full plan documents for plan details including exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. 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

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.

Estate Guidance

Available to all employees covered under our Life Insurance policy.

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

Available to all employees covered under our Life Insurance policy.

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

Available to all employees covered under our Life Insurance Policy.

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

Available to all employees covered under our Life Insurance Policy.

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

Funeral Planning

Available to all employees covered under our Life Insurance Policy.

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.

Scan for **more resources.**

EAP (Employee Assistance Program)

Available to all employees covered under our Life Insurance Policy.

With EAP through ComPsych EAP, employees have access to resources when and where you need it – day or night. Visit guidanceresources.com when you create an account, enter **PrincipalPremier3** as the program name. EAP offers a range of services to help employees live their best lives including 3 counseling sessions per person per issue per year. To get started, you can also call the 24/7 phone consultation service at 833-955-3389.

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.

© 2012-2014 Zywave, Inc. All rights reserved. Not to be construed as legal advice

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.l.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.*

401(K) Enterprise Plan

OMB Control number 1210-0040; Expiration Date 03/31/2026

SUMMARY ANNUAL REPORT FOR
ST. CROIX CHIPPEWA INDIANS OF WISCONSIN ENTERPRISE 401(K) PLAN

This is a summary of the annual report Form 5500 Annual Return/Report of Employee Benefit Plan of St. Croix Chippewa Indians of Wisconsin Enterprise 401(k) Plan and Employer Identification Number 39-1210835/Plan Number 002 for the plan year 01/01/2024 through 12/31/2024. The Form 5500 annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA). Your plan is a single employer, defined contribution plan with the following characteristics: profit sharing, ERISA section 404(c), total participant-directed account, code section 401(k) feature, code section 401(m) arrangement, total or partial participant-directed account.

Basic Financial Statement

Benefits under the plan are provided by a trust fund. Plan expenses were $132,172. These expenses included $2,875 in administrative expenses and $129,297 in benefits paid to participants and beneficiaries, and $0 in other expenses. A total of 143 persons were participants in or beneficiaries of the plan at the end of the plan year, although not all of these persons had yet earned the right to receive benefits.

The value of plan assets, after subtracting liabilities of the plan, was $1,283,308 as of the end of the plan year, compared to $814,027 as of the beginning of the plan year. During the plan year the plan experienced a change in its net assets of $469,281. This change includes unrealized appreciation or depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. The plan had total income of $601,453, including employer contributions of $133,821, employee contributions of $354,918, and earnings from investments of $112,550.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

1. An accountant's report.
2. Assets held for investment.
3. Information regarding any common or collective trusts, pooled separate accounts, master trusts or 103-12 investment entities in which the plan participates.

To obtain a copy of the full annual report, or any part thereof, write or call the office of Kelly Bertuleit, who is a representative of the plan administrator, at 4264 Admin Rd., Webster, WI 54893 and phone number, 715-349-2195.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report.

You also have the legally protected right to examine the annual report at the main office of the plan: 4264 Admin Rd., Webster, WI 54893, and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. The annual report is also available online at the Department of Labor website www.efast.dol.gov.

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.

St. Croix Chippewa Indians of Wisconsin Health Plan: 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, 2025. V 0.6.0. 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://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 771
Health Insurance Buy-In Program (HIBI)
Website: https://www.mycohibi.com/
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
Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

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://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website:
https://chfs.ky.gov/agencies/dms
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.mymaineconnection.gov/benefits/s/?language=en_US
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: 711
Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
Website:
https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005
MONTANA – Medicaid
Website:
https://dphhs.mt.gov/MontanaHealthcarePrograms/MemberServices
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. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website:
http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)
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: https://www.hhs.nd.gov/healthcare
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 and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)
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: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website:
https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website:
https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website:
https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/
VERMONT – Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/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/medicaid/index.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, 2025, 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 Health Plan 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 9.96% of household income for the plan year beginning in 2026, 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 may include other health and welfare benefit offerings, 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, 4264 Admin Rd., 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, 4264 Admin Rd., 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, 4264 Admin Rd., 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, 4264 Admin Rd., 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, 4264 Admin Rd., 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, 4264 Admin Rd., 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, 4264 Admin Rd., 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 Government and Commercial, and Working Tribal Health Plans 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: November 19, 2025
Name of Entity/Sender: St. Croix Chippewa Indians of Wisconsin
Contact--Position/Office: Human Resources
Address: 4264 Admin Rd., Webster WI 54893
Phone Number: 715-349-2195

Important Notice from St. Croix Chippewa Indians of Wisconsin High-Deductible Health Plan 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 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. 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. St. Croix Chippewa Indians of Wisconsin Health Plan has determined that the prescription drug coverage offered by St. Croix Chippewa Indians of Wisconsin 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 St. Croix Chippewa Indians of Wisconsin 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 St. Croix Chippewa Indians of Wisconsin. 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 St. Croix Chippewa Indians of Wisconsin, 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 St. Croix Chippewa Indians of Wisconsin Health Plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
Since the coverage under the St. Croix Chippewa Indians of Wisconsin 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 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.

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).
Date: November 19, 2025
Name of Entity/Sender: St. Croix Chippewa Indians of Wisconsin
Contact--Position/Office: Human Resources
Address: 4264 Admin Rd., Webster WI 54893
Phone Number: 715-349-2195 ❖