Tatonka
EDUCATION SERVICES

"We are dedicated to the charter school movement and the immense impact it can have on the lives of children and the surrounding community." Don't just take our word for it!

2023 TATONKA EDUCATION SERVICES BENEFITS GUIDE

2023 BENEFITS OVERVIEW

FOR BENEFITS EFFECTIVE 1/1/2023-12/31/2023

The Tatonka Education Services annual insurance open enrollment period is about to begin.

We recognize the importance of benefits within the overall compensation package provided to all of our eligible employees. This year when we reviewed our employee benefits options, we focused not only on providing quality medical plans but also on controlling the cost and financial risk for our employees. We offer multiple options to meet the individual needs of our employees and their dependents.

ENROLL ONLINE AT EASE!

NOT SURE HOW TO GET STARTED? DON'T WORRY!

Prior to open enrollment, you will receive step-by-step enrollment instructions by email from our HR team.

Until then, now is the perfect time to prepare by doing the following:

- Check that your personal information is accurate on Ease
- Review the benefits in which you are currently enrolled,
- Take a look at the changes for 2023, and
- Check out the plans being offered for the coming year.

In this booklet, you'll find easy-to-understand instructions to help you make your benefit decisions.

As always, we value you as a member of the Tatonka Education Services family and look forward to a healthy and safe 2023.

TIP REMEMBER! Open enrollment is the one time of year you can make any adjustments you'd like for the upcoming plan year.

Throughout this guide you will find video and link icons that will take you to resources that provide additional information on the benefits available to you.

Tatonka EDUCATION SERVICES

IMPORTANT DATES

Open enrollment runs

December 1,2022 – December 14, 2022

CONTACT INFORMATION

If you have any questions regarding your benefits, please contact United Healthcare, Equitable, your Tatonka Education Services Benefits Representative, or our CBIZ representative listed below.

MEDICAL INSURANCE

United Healthcare
www.uhc.com
1-800-444-6222

DENTAL, VISION, GROUP LIFE/AD&D, VOL LIFE, SHORT-TERM DISABLITY, & LONG-TERM DISABILLITY

Equitable
www.equitable.com
1-877-222-2144

ONLINE ENROLLMENT PORTAL

Ease
www.ease.com
1-702-800-2690

CBIZ REPRESENTATIVE

Steve Sosnowski
steve.sosnowski@cbiz.com
614-793-2448

MEDICAL INSURANCE

YOUR HEALTH PLAN OPTIONS

As a full-time employee of Tatonka Education Services you have the choice between four medical plan options.

For each, your deductible will run from JANUARY 1 – DECEMBER 31.

While all 4 plans give you the option of using out-of-network providers, you can save money by using in-network providers because United Healthcare has negotiated significant discounts with them. If you choose to go out-of-network, you'll be responsible for the difference between the actual charge and United Healthcare UCR (Usual, Customary and Reasonable) charge, plus your out-of-network deductible and coinsurance.

Get the most out of your insurance by using in-network providers.

FREQUENTLY ASKED QUESTIONS

TIP **How many hours do I need to work to be eligible for insurance benefits?**

You must be a full-time employee working a minimum of 30 hours per week on a regular basis.

? **Will I receive a new Medical ID card?**

You will receive an ID card in the mail if you are electing medical coverage.

? **Does the deductible run on a calendar year or policy year basis?**

A calendar year basis.

? **How long can I cover my dependent children?**

Dependent children are eligible until the end of the month in which they turn age 26.

? **I just got hired. When will my benefits become effective?**

Your medical insurance benefit will begin on the first day of employment for regular full-time employees.

Medical Plan FAQs

HOW TO GET STARTED

1. SELECT YOUR MEDICAL PLAN

- OPTION 1: $250/$500 PPO
- OPTION 2: **$1,250/$2,500 PPO**
- OPTION 3: **$2,500/$5,000 PPO**
- OPTION 4: **$3,500/$7,000 PPO**

PPO PLANS

THE BENEFITS OF THESE TYPES OF PLANS

- Allows participants to see any doctor facility in their network without a referral
- Out-of-network benefits also allow participants to see providers not within the network, but at a cost
- Participants are also able to choose specialists without a consulting a primary care physician and can be admitted to any hospital or facility of their choosing

PPO PLANS, CONT.

THE BENEFITS OF THESE TYPES OF PLANS

- You have copays for office and specialty visits rather than an HSA account where you owe the full amount until your deductible has been met
- PPO networks are much larger than HMO networks
- You can make your own healthcare decisions

CARE OPTIONS & WHEN TO USE THEM

YOUR CARE OPTIONS

While we recommend that you seek routine medical care from your primary care physician whenever possible, there are alternatives available to you. Services may vary, so it's a good idea to visit the care provider's website. Be sure to check that the facility is in-network by calling the toll-free number on the back of your medical ID card, or by visiting United Healthcare.

PRIMARY CARE

- Routine, primary/preventive care
- Non-urgent treatment
- Chronic disease management

For routine, primary/ preventive care or non-urgent treatment, we recommend going to your doctor's office. Your doctor knows you and your health history and has access to your medical records. You may also pay the least amount out of pocket.

TELEHEALTH

- Cold/flu
- Diarrhea
- Fever
- Rash
- Sinus problems

Retail Telehealth, or a "virtual visit," lets you see and talk to a doctor from your mobile device or computer without an appointment, anytime and anywhere! United Healthcare partners with American Well (Amwell) and Doctor on Demand to bring you care from the comfort and convenience of your home or wherever you are.

CONVENIENCE CARE

- Common infections (ear infections, pink eye, strep throat & bronchitis)
- Flu shots
- Pregnancy tests
- Vaccines
- Rashes
- Screenings

These providers are a good alternative when you are not able to get to your doctor's office and your condition is not urgent or an emergency. They are often located in malls or retail stores (such as CVS, Walgreens, Wal-Mart and Target), and generally serve patients 18 months of age or older without an appointment. Services may be provided at a lower out-of-pocket cost than an urgent care center.

URGENT CARE

- Sprains
- Small cuts
- Strains
- Minor infections
- Sore throats
- Mild asthma attacks
- Back pain or strains

Sometimes you need medical care fast, but a trip to the emergency room may not be necessary. During office hours, you may be able to go to your doctor's office. Outside regular office hours — or if you can't be seen by your doctor immediately — you may consider going to an Urgent Care Center where you can generally be treated for many minor medical problems faster than at an emergency room.

EMERGENCY ROOM

- Heavy bleeding
- Large open wounds
- Chest pain
- Spinal injuries
- Difficulty breathing
- Major burns
- Severe head injuries

An emergency medical condition is any condition (including severe pain) which you believe that, without immediate medical care, may result in serious injury or is life threatening. Emergency services are always considered in-network. If you receive treatment for an emergency in a non-network facility, you may be transferred to an in-network facility once your condition has been stabilized.

If you believe you are experiencing a medical emergency, go to the nearest emergency room or call 9-1-1, even if your symptoms are not described here.

Primary Care vs. Urgent Care vs. ER

MEDICAL INSURANCE

United Healthcare	Option 1: PPO $250 Plan	Option 2: PPO $1,250 Plan
	Employee Cost Per Paycheck (24)	Employee Cost Per Paycheck (24)
Employee Employee + Spouse Employee + Child(ren) Employee + Family	$131.87 $559.94 $495.73 $923.80	$60.32 $416.84 $363.36 $719.88
	In-Network	In-Network
Deductible (1) Individual / Family	$250 / $500	$1,250 / $2,500
Coinsurance (Member Pays)	10%	20%
Out-of-Pocket Maximum (2) Individual / Family	$3,650 / $7,300	$7,500 / $15,000
Office Visits Preventative Care Primary Care Physician / Specialist Diagnostic Lab / X-Ray Urgent Care Virtual Visit	 Covered at 100% $10 / $20 copay Deductible then 10% $20 copay Covered In Full	 Covered at 100% Designated N: $20; N: $50 Designated N: $40; N: $100 Deductible then 20% $20 copay Covered In Full
Hospital Visits Inpatient Care (Facility / Physician) Outpatient Surgery Major Diagnostics & Imaging Emergency Room	 Deductible then 10% Deductible then 10% Deductible then 10% Deductible then 10%	 Deductible then 20% Deductible then 20% Deductible then 20% Deductible then 20%
Prescription Drug Deductible Retail Tier 1 / 2 / 3 / 4 Copay Mail Order (90-day supply)	 Does Not Apply $10 / $40 / $85 / $250 $25 / $100 / $212.50 / $625	 Does Not Apply $10 / $55 / $100 / $350 $25 / $137.50 / $250 / $875
	Out-of-Network (3)	Out-of-Network (3)
Deductible Individual / Family	$7,500 / $15,000	$7,500 / $15,000
Coinsurance (Member Pays)	50%	50%
Out-of-Pocket Maximum Individual / Family	$15,000 / $30,000	$15,000 / $30,000

(1) Family deductible is embedded; an individual covered in a family will not exceed the individual deductible

(2) Out-of-Pocket maximum includes all cost-sharing: deductible, coinsurance and copays

(3) All Out-of-Network services subject to deductible, coinsurance and balance billing

Premiums can be withheld from your paycheck on a pre-tax basis for Medical, Dental, and Vision insurance. Based upon your individual tax bracket, this could save you a considerable amount of money.

Your election can only be changed during the plan year if you experience a qualifying life status change. You must notify Human Resources within 30 days of the event.

Both plans are detailed in United HealthCare's 2023 Certificate of Coverage (COC). This is a brief summary only. For exact terms and conditions, please refer to your certificate.

IMPORTANT: To see how United Healthcare is handling testing, inpatient hospital admissions (including treatment), telehealth visits, etc. as a result of COVID-19 visit their website here: https://www.uhcprovider.com/en/resource-library/news/Novel-Coronavirus-COVID-19.html

MEDICAL INSURANCE, CONTINUED

United Healthcare	Option 3: PPO $2,500 Plan	Option 4: PPO $3,500 Plan
	Employee Cost Per Paycheck (24)	Employee Cost Per Paycheck (24)
Employee Employee + Spouse Employee + Child(ren) Employee + Family	$43.77 $383.74 $332.75 $672.72	$0.00 – no cost to you $296.20 $251.77 $547.97
	In-Network	In-Network
Deductible (1) Individual / Family	$2,500 / $5,000	$3,500 / $7,000
Coinsurance (Member Pays)	20%	40%
Out-of-Pocket Maximum (2) Individual / Family	$5,250 / $10,500	$8,650 / $17,300
Office Visits Preventative Care Primary Care Physician / Specialist Diagnostic Lab / X-Ray Urgent Care Virtual Visit	 Covered at 100% $25 / $50 copay Deductible then 20% $25 copay Covered In Full	 Covered at 100% $45 / $90 copay Deductible then 40% $75 copay Covered In Full
Hospital Visits Inpatient Care (Facility / Physician) Outpatient Surgery Major Diagnostics & Imaging Emergency Room	 Deductible then 20% Deductible then 20% Deductible then 20% Deductible then 20%	 Deductible then 40% Deductible then 40% Deductible then 40% Deductible then 40%
Prescription Drug Deductible Retail Tier 1 / 2 / 3 / 4 Copay Mail Order (90-day supply)	 $250 per person / $500 per family , then: $15 / $55 / $120 / $350 $37.50 / $137.50 / $300 / $875	 $350 per person / $700 per family, then: $15 / $60 / $125 / $350 $37.50 / $150 / $312.50 / $875
	Out-of-Network (3)	Out-of-Network (3)
Deductible Individual / Family	$7,500 / $15,000	$7,500 / $15,000
Coinsurance (Member Pays)	50%	50%
Out-of-Pocket Maximum Individual / Family	$15,000 / $30,000	$15,000 / $30,000

(1) Family deductible is embedded; an individual covered in a family will not exceed the individual deductible

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TELEHEALTH

TELEHEALTH SAVINGS

AMWELL & DOCTOR ON DEMAND

Retail Telehealth, or a "virtual visit," lets you see and talk to a doctor from your mobile device or computer without an appointment. United Healthcare partners with American Well (Amwell) & Doctor on Demand to bring you care from the comfort and convenience of your home or wherever you are.

Conditions commonly treated through a virtual visit:

- Bladder infection/ urinary tract infection
- Bronchitis
- Cold/flu
- Diarrhea
- Fever
- Migraine/ headaches
- Pink eye
- Rash
- Sinus problems
- Sore throat

Most visits take about 10-15 minutes, and your doctor can write a prescription, if needed, that you can pick up at your local pharmacy.

GET STARTED TODAY WITH AMWELL OR DOCTOR ON DEMAND!

STEP 1: Download the Amwell or Doctor on Demand Mobile App

Either app can be downloaded directly to your smart phone or tablet. Or, if you prefer the web, visit www.amwell.com or doctorondemand.com.

STEP 2: Enroll

Create an account in a few simple steps. Be sure to include your United Healthcare insurance information when creating your account. Your information is stored securely.

STEP 3: Choose a doctor

View a list of available doctors, their experience and ratings, and select one.

STEP 4: Visit

Engage in a secure live video visit directly from the web or your mobile device in high-quality streaming video.

RX SAVINGS

OPTUMRX

STEP1: Manage your new pharmacy benefits

- Visit www.optumrx.com if you are a first time visitor, click REGISTER NOW. Please have your member ID card available to reference.
- Once on the Rx page, fill in your email address and mobile phone number to start receiving email and/or text alerts!

STEP 2: Review your savings options and share with your doctor

- Switch from Pharmacy A to Pharmacy B.
- Switch to a different equally-effective medication.

STEP 3: Start saving and managing your prescriptions

GOODRX

GoodRx compares prices for your prescriptions at pharmacies near you. GoodRx does not sell medications, they tell you where you can get the best deal on them.

GoodRx will show you prices, coupons, discounts, and savings tips for your prescriptions.

You can access GoodRx by going to www.goodrx.com, or by downloading the app.

FLEXIBLE SPENDING ACCOUNTS (FSA)

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

This account enables you to pay medical, dental, vision, and prescription drug expenses that may or may not be covered under your insurance program (or your spouse's) with pre-tax dollars. You can also pay for dependent health care, even if you choose single (vs. family) coverage. The total amount of your annual election is available to you at the beginning of the plan year, reducing the chance of having a large out-of-pocket expense early in the plan year. $610 can be carried over into the next plan year but any unused portion above $610 at the end of the plan year is forfeited.

Eligible Expenses Examples

- Coinsurance and copayments
- Contraceptives
- Crutches
- Dental expenses
- Dentures
- Diagnostic expenses
- Eyeglasses, including exam fee
- Handicapped care and support
- Nutrition counseling
- Hearing devices and batteries
- Hospital bills
- Deductible amounts
- Laboratory fees
- Licensed practical nurses
- Orthodontia
- Orthopedic shoes
- Oxygen
- Prescription drugs
- Psychiatric care
- Psychologist expenses
- Routine physical
- Seeing-eye dog expenses
- Prescribed vitamin supplements (medically necessary)

HOW THE HEALTH CARE FLEXIBLE SPENDING ACCOUNT WORKS

When you have out-of-pocket expenses (such as copayments and deductibles), you can either use your FSA debit card to pay for these expenses at qualified providers or submit an FSA claim form with proper documentation to CBIZ Flex Department. Reimbursement is issued to you through direct deposit into your bank account, or if you prefer, a check can be issued to you.

2023 Maximum Contributions

Health Care Flexible Spending Account	$3,050 max
Dependent Care Expense Account	$5,000 max

Click here for the full list of Healthcare FSA Eligible Expenses

What Is A Flexible Spending Account?

1. SELECT YOUR FSA ACCOUNTS

- HEALTH CARE FLEXIBLE SPENDING ACCOUNT
- DEPENDENT CARE EXPENSE ACCOUNT

DEPENDENT CARE EXPENSE ACCOUNT

This account gives you the opportunity to redirect a portion of your annual pay on a pre-tax basis to pay for dependent care expenses. An eligible dependent is any member of your household for whom you can claim expenses on your Federal Income Tax Form 2441, "Credit for Child and Dependent Care Expenses." Children must be under age 13. Care centers which qualify include dependent care centers, preschool educational institutions, and qualified individuals (as long as the caregiver is not a family member and reports income for tax purposes). Before deciding to use the Dependent Care Expense Account, it would be wise to compare its tax benefit to that of claiming a child care tax credit when filing your tax return. You may want to check with your tax advisor to determine which method is best for you and your family. Any unused portion of your account balance at the end of the plan year is forfeited.

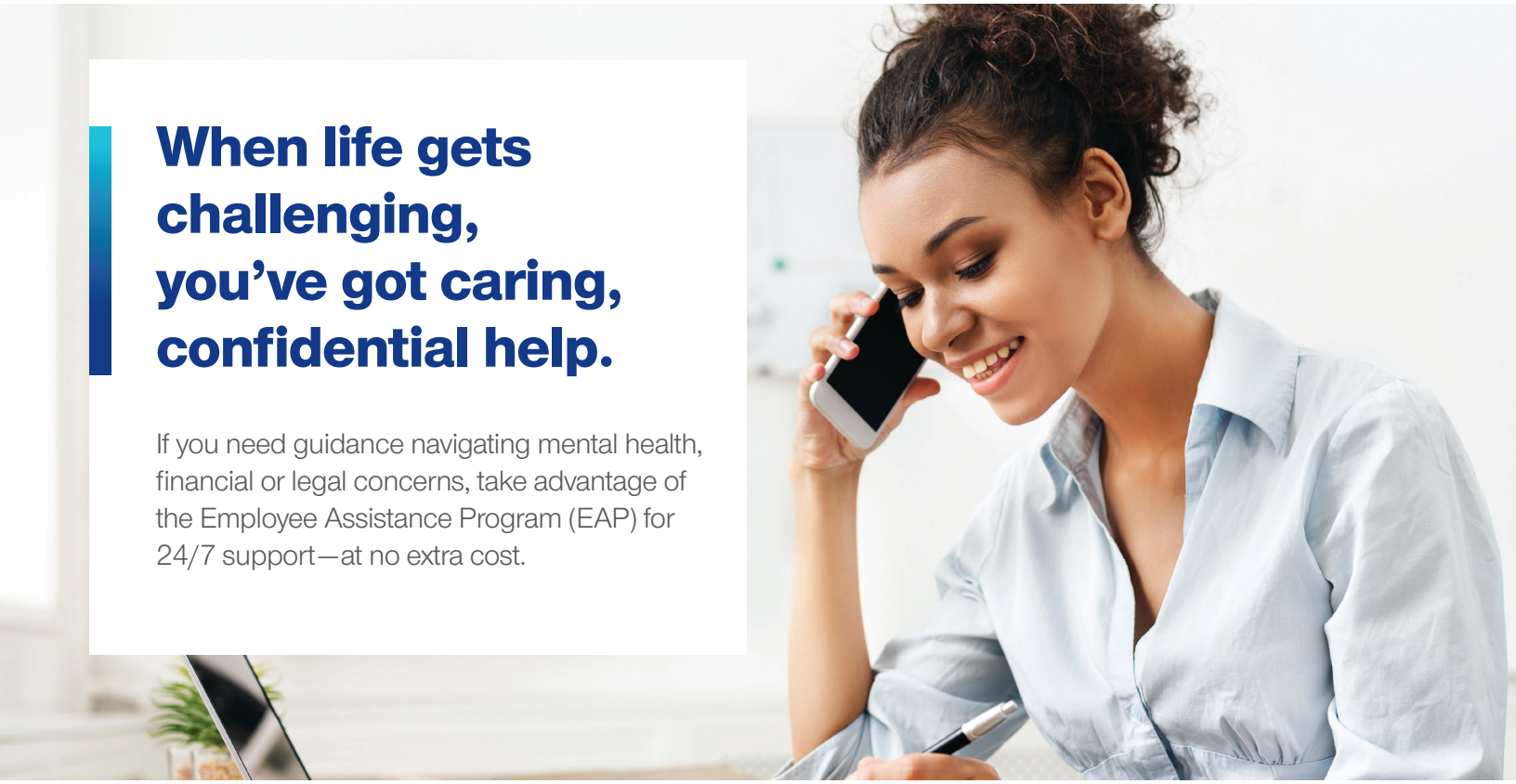
CONTACT INFORMATION

Request a full statement of your accounts at any time by calling 800-815-3023 or log on to www.myflexonline.com to review your FSA balance. The address to mail claims to is CBIZ Payroll, Attn: Flex, 2797 Frontage Rd, Ste 2000, Roanoke, VA 24017.

AT WWW.MYFLEXONLINE.COM YOU CAN:

Sample Instructions

- View account information and activity
- File claims
- Manage your profile
- View notifications



When life gets challenging, you've got caring, confidential help.

If you need guidance navigating mental health, financial or legal concerns, take advantage of the Employee Assistance Program (EAP) for 24/7 support—at no extra cost.

It's good to know you're not alone.

Reaching out to an EAP consultant is a good first step. They're trained to understand your concerns so they can connect you with the consultant or service best able to help you:

- Address depression, anxiety or substance use issues.
- Improve relationships at home or work.
- Manage stress.
- Work through emotional issues or grief.
- Assistance with legal and financial concerns.

One call puts you in touch with a clinician, counselor, mediator, lawyer or financial adviser who could help change your life for the better.

Call the member phone number on your health plan ID card and ask to speak to an EAP consultant. Or, contact EAP directly 24/7 at 1-888-887-4114.

UnitedHealthcare®

DENTAL INSURANCE

2. REVIEW YOUR DENTAL PLANS

- BASE PLAN

EQUITABLE IS THE DENTAL CARRIER FOR 2023.

If you're looking for dental coverage that covers most of your common needs, the following is a highlight of the Base Plan. By combining affordability with protection, this plan delivers you the coverage you want for preventive and basic services, plus the protection you need for major services.

Although you can seek services with any dentist, it is to your advantage to utilize a network dentist in order to achieve the greatest benefit and cost savings. If you choose to go out-of-network, you may be balanced billed by your dentist for charges above the insurance carriers payment.

What Is Dental Insurance?

In-Network Providers:
Provider is reimbursed based on contracted fees and cannot balance bill you.

Out-of-Network Providers:
Provider is reimbursed based on Reasonable and Customary standards and balance billing is possible.

DENTAL INSURANCE— BASE PLAN OPTION AND COSTS

Equitable	Employee Cost Per Paycheck (24)		
Employee Employee + Spouse Employee + Child(ren) Employee + Family	$0.00 — no cost to you $10.91 $15.00 $29.29		
	In-Network	Out-of-Network	
Deductible Individual / Family	$50 / $150		Applies to Basic & Major Services
Annual Maximum	$1,000		Applies to Preventative, Basic & Major Services
	Carrier Pays		
Diagnostic / Preventive Services	100%	100%	■ Oral Evaluations ■ Cleanings ■ X-Rays ■ Fluoride Treatments (for dependents <19) ■ Sealants (for dependents <14) ■ Labs & Tests
Basic Services	60%	60%	■ Fillings ■ Endodontics ■ Periodontics ■ Space Maintainers ■ Simple & Surgical Extractions ■ General Anesthesia
Major Services	40%	40%	■ Single Crowns ■ Inlays/Onlays ■ Bridges & Dentures ■ Prosthodontics ■ Implants
Orthodontia Services	NOT COVERED ON THE BASE PLAN		NOT COVERED ON THE BASE PLAN

FIND A DENTAL PROVIDER

To find an Equitable Dental Provider in your area, visit the website at https://equitable.com/employee-benefits/find-a-provider/find-a-provider-dental-search

SAMPLE INSTRUCTIONS

- Under **"Find a Dentist"** Select your city and state **OR** enter your zip code, then a drop down will appear underneath— click **"Go"** to the right of the screen
- Select a provider from the list

DENTAL INSURANCE

2. REVIEW YOUR DENTAL PLANS

- BUY-UP PLAN

EQUITABLE IS THE DENTAL CARRIER FOR 2023.

If greater benefits are more your speed, the following is a highlight of the Buy-Up Plan, which offers dependent child orthodontic coverage and a higher benefit percentage for basic and major services.

Although you can seek services with any dentist, it is to your advantage to utilize a network dentist in order to achieve the greatest benefit and cost savings. If you choose to go out-of-network, you may be balanced billed by your dentist for charges above the insurance carriers payment.

What Is Dental Insurance?

In-Network Providers:
Provider is reimbursed based on contracted fees and cannot balance bill you.

Out-of-Network Providers:
Provider is reimbursed based on Reasonable and Customary standards and balance billing is possible.

DENTAL INSURANCE— BUY-UP PLAN OPTION AND COSTS

Equitable	Employee Cost Per Paycheck (24)		
Employee Employee + Spouse Employee + Child(ren) Employee + Family	$3.23 $17.35 $25.35 $44.47		
	In-Network	Out-of-Network	
Deductible Individual / Family	$50 / $150		Applies to Basic & Major Services
Annual Maximum	$1,000		Applies to Preventative, Basic & Major Services
	Carrier Pays		
Diagnostic / Preventive Services	100%	100%	■ Oral Evaluations ■ Cleanings ■ X-Rays ■ Fluoride Treatments (for dependents <19) ■ Sealants (for dependents <14) ■ Lab & Tests
Basic Services	80%	80%	■ Fillings ■ Endodontics ■ Periodontics ■ Space Maintainers ■ Simple & Surgical Extractions / Removal of impacted teeth ■ General Anesthesia
Major Services	50%	50%	■ Single Crowns ■ Inlays/Onlays ■ Bridges & Dentures ■ Prosthodontics ■ Implants
Orthodontia Services	**50% up to the $1,000 lifetime maximum**		■ **Diagnostics & Treatment (for dependents <19)**

FIND A DENTAL PROVIDER

To find an Equitable Dental Provider in your area, visit the website at https://equitable.com/employee-benefits/find-a-provider/find-a-provider-dental-search

SAMPLE INSTRUCTIONS

- Under **"Find a Dentist"** Select your city and state **OR** enter your zip code, then a drop down will appear underneath— click **"Go"** to the right of the screen
- Select a provider from the list

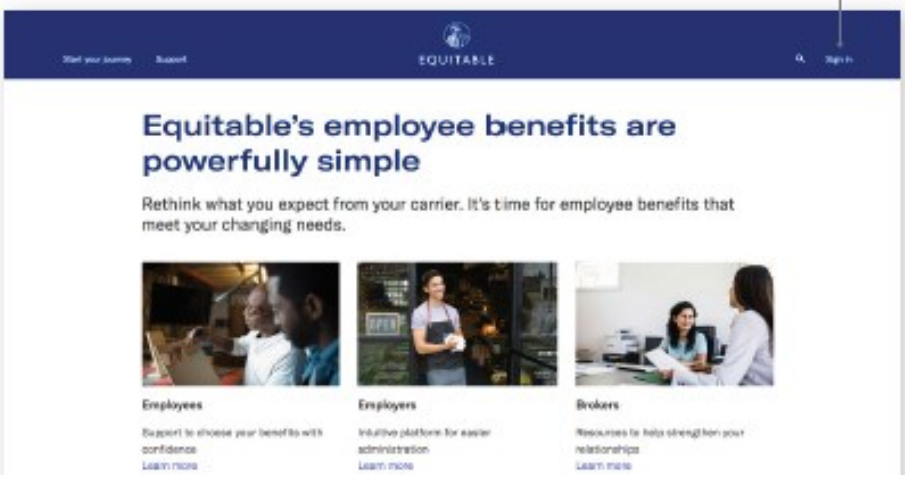
Register on EB360® to receive your dental ID card

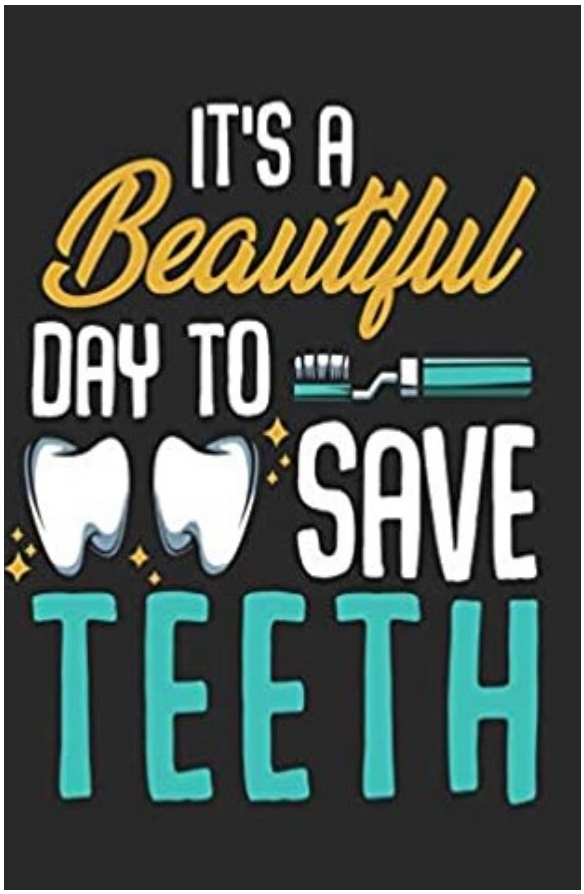
Easily download a personalized ID card right from EB360® at any time. Simply review dental information on your smartphone or tablet via your EB360® customized dashboard. Effortlessly print your card so you can carry it with you.

Welcome to Equitable!

To register:

1 Go to **equitable.com/employeebenefits** and click **Sign in**





2 Select **Individual** and then select **Employer Provided Benefits.**

3 Follow the instructions and input your last name, date of birth and Social Security number for a one-time validation of your identity.

4 You will be asked to create an individual User ID.

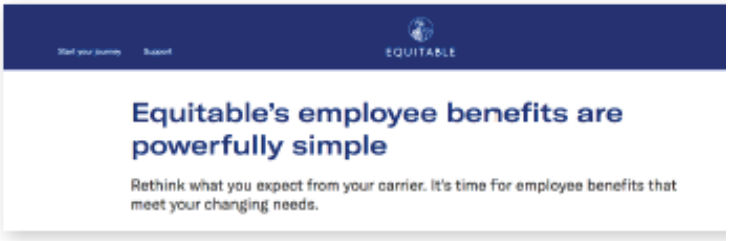
5 Select **Secret Questions** from the drop-down menu. These will be used for password verification in case you forget or want to change your password later.

Once you've registered, you will receive an email confirmation, as well as a letter of confirmation, which will be mailed to your address of record.

To find an in-network provider, visit **equitable.com/finddentist.**

To print your dental ID card:

1 Go to **equitable.com/employeebenefits** and click on **Sign in** on the top right. Enter the User ID and password you set up during registration.



2 Click **Print ID card** to the right of the details of your dental policy. The ID Card will open up in a separate tab as a PDF. You can save it to your device or print it as many times as you need.

3 If you need assistance registering or printing your ID card, please contact the customer service team at (866) 274-9887.

VISION INSURANCE

3. REVIEW YOUR VISION PLAN

■ BASE PLAN

EQUITABLE IS THE VISION CARRIER FOR 2023

Our vision options met your needs, whether you like to change your frames and lenses often, or simply make sure your eyes and health are in good working order. **The Base Plan** offers a 24 month frequency of services for frames, a $25 material copay and a $150 allowance for frames and lenses.

Although you can seek vision services with any provider, it is to your advantage to utilize a network provider in order to achieve the greatest benefits and cost savings. If you go out-of-network, your benefit is based on a reimbursement schedule.

Also, if you are considering Lasik surgery or other non-covered benefits, there are discounts available with some providers. To find a participating provider, go to https://equitable.com/employee-benefits/find-a-provider/find-a-provider-vision-search

What Is Vision Insurance?

VISION INSURANCE— BASE PLAN OPTION AND COSTS

Equitable	**Employee Cost Per Paycheck (24)**	
Employee Employee + Spouse Employee + Child(ren) Employee + Family	$0.00 — no cost to you $2.76 $3.15 $6.67	
	In-Network	**Out-of-Network**
Examination Copay	$10 copay	Reimbursement Up to $45
Frequency of Service Exam Lenses Frames	 Every 12 months Every 12 months Every 24 months	
Lenses Single Bifocal Trifocal	 $25 copay; 100% covered $25 copay; 100% covered $25 copay; 100% covered	 Reimbursement Up to $30 Up to $50 Up to $65
Frames	$25 copay; $150 allowance, 20% off balance over $150	Reimbursement Up to $70
Conventional Contacts	$25 copay, $150 allowance	Reimbursement Up to $105
Medically Necessary Contacts	$25 copay, paid-in-full	Reimbursement Up to $210

FIND A VISION PROVIDER

To find an Equitable Vision Provider in your area, visit the website at https://equitable.com/employee-benefits/find-a-provider/find-a-provider-vision-search

SAMPLE INSTRUCTIONS

- Under **"Find a Vision"** Select your city and state **OR** enter your zip code, then a drop down will appear underneath— click **"Go"** to the right of the screen
- Select a provider from the list

VISION INSURANCE

3. REVIEW YOUR VISION PLAN

- BUY-UP PLAN

EQUITABLE IS THE VISION CARRIER FOR 2023

Tatonka offers its employees the choice of two vision plans and both plans are very similar. The main differences are the copays for eyeglass lenses, the lens and frame allowance and how often the plan covers new frames. **The Buy-Up Plan** offers a 12 month frequency of services for frames, a $10 material copay and a $200 allowance for frames and lenses.

Although you can seek vision services with any provider, it is to your advantage to utilize a network provider in order to achieve the greatest benefits and cost savings. If you go out-of-network, your benefit is based on a reimbursement schedule.

Also, if you are considering Lasik surgery or other non-covered benefits, there are discounts available with some providers. To find a participating provider, go to https://equitable.com/employee-benefits/find-a-provider/find-a-provider-vision-search

What Is Vision Insurance?

VISION INSURANCE— BUY-UP OPTION AND COSTS

Equitable	Employee Cost Per Paycheck (24)	
Employee Employee + Spouse Employee + Child(ren) Employee + Family	$1.10 $4.97 $5.51 $10.45	
	In-Network	Out-of-Network
Examination Copay	$10 copay	Reimbursement Up to $45
Frequency of Service Exam Lenses Frames	Every 12 months Every 12 months Every 12 months	
Lenses Single Bifocal Trifocal	 $10 copay; 100% covered $10 copay; 100% covered $10 copay; 100% covered	Reimbursement Up to $30 Up to $50 Up to $65
Frames	$10 copay; $200 allowance, 20% off balance over $200	Reimbursement Up to $70
Conventional Contacts	$10 copay, $200 allowance	Reimbursement Up to $105
Medically Necessary Contacts	$10 copay, paid-in-full	Reimbursement Up to $210

FIND A VISION PROVIDER

To find an Equitable Vision Provider in your area, visit the website at https://equitable.com/employee-benefits/find-a-provider/find-a-provider-vision-search

SAMPLE INSTRUCTIONS

- Under **"Find a Vision"** Select your city and state **OR** enter your zip code, then a drop down will appear underneath— click **"Go"** to the right of the screen
- Select a provider from the list

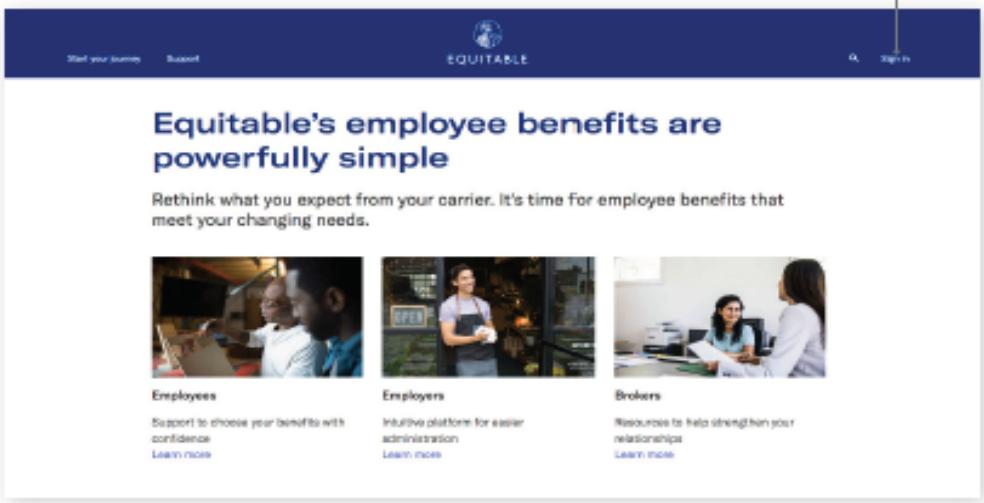
How to print your member vision card and view benefits

Employees can simply use their Social Security number to verify coverage with their provider. To easily download a member vision card, you have two options: From EB360® or directly from VSP® at any time. Simply review vision information on your smartphone or tablet via your EB360® personalized dashboard through VSP®. Effortlessly print your own card so you can carry it with you.

Welcome to Equitable!

Access your Member Vision Card on the VSP® Vision Care's website by following the instructions below:

1 Go to **equitable.com/employeebenefits** and click **Sign in**



2 Enter the User ID and password you set up during registration.

3 Click **Visit Website** to the right of the details of your vision policy. The VSP® website will open up in a separate tab in your browser.

4 Create an account and log in at **https://www.vsp.com/register.html.**

5 Access and print your Member Vision Card.

6 Don't forget to view special offers from VSP® by visiting: **vsp.com/specialoffers.**

For additional assistance, contact our Customer Service Team at (866) 274-9887, Monday - Thursday 8:00 a.m.-6:30 p.m. ET. Friday 8:00 a.m.-5:30 p.m ET.

LIFE INSURANCE AND AD&D

4. REVIEW YOUR LIFE INSURANCE POLICY

- ADD YOUR SPOUSE
- ADD YOUR DEPENDENTS
- INCREASE YOUR COVERAGE

BASIC LIFE AND AD&D

Tatonka Education Services provides $10,000 in Basic Life and Accidental Death & Dismemberment (AD&D) insurance to its employees.

This coverage is offered through Equitable at no cost to you.

What Is Life And AD&D Insurance?

VOLUNTARY LIFE AND DEPENDENT LIFE

You can also purchase additional Life and AD&D Coverage beyond what Tatonka Education Services provides. Equitable guarantee issues coverage during your initial enrollment period — which means you can't be turned down for coverage based on medical history.

- **Voluntary Employee Life & AD&D:** From $10,000 **to** $500,000, in $10,000 increments, not to exceed 5 times the employees basic annual earnings. Guarantee issue up to $150,000.
- **Optional Spouse Life & AD&D:** Up to 50% of the employee amount, to a $250,000 maximum , in $5,000 increments. Guarantee issue up to $50,000.
- **Optional Child Life & AD&D:** From birth to 14 days, a $500 benefit. From 15 days to age 26, a $10,000 maximum benefit. Guarantee issue is $10,000.

If you do not enroll in the Voluntary Life and AD&D plan during your initial enrollment period, you will be required to complete an Evidence of Insurability form and it must be approved by Equitable before you are able to get coverage in the future.

You must be enrolled in voluntary life and/or ADA& life coverage in order for your spouse, and/or eligible dependent children to enroll.

VOLUNTARY LIFE AND DEPENDENT LIFE OPTIONS AND COSTS PER MONTH

Equitable	Rates per $1,000 of benefit		
	Age	Employee	Spouse
Voluntary Life	<24	$0.035	$0.035
	25-29	$0.035	$0.035
	30-34	$0.045	$0.045
	35-39	$0.064	$0.064
	40-44	$0.107	$0.107
	45-49	$0.172	$0.172
	50-54	$0.272	$0.272
	55-59	$0.392	$0.392
	60-64	$0.461	$0.461
	65-69	$0.738	$0.738
	70-74	$1.653	
	75-79	$1.653	
	80+	$1.653	
Voluntary AD&D *Per $1,000*	$.020 $.050 for Child(ren)		

IDENTITY THEFT AND PRIVACY PROTECTION

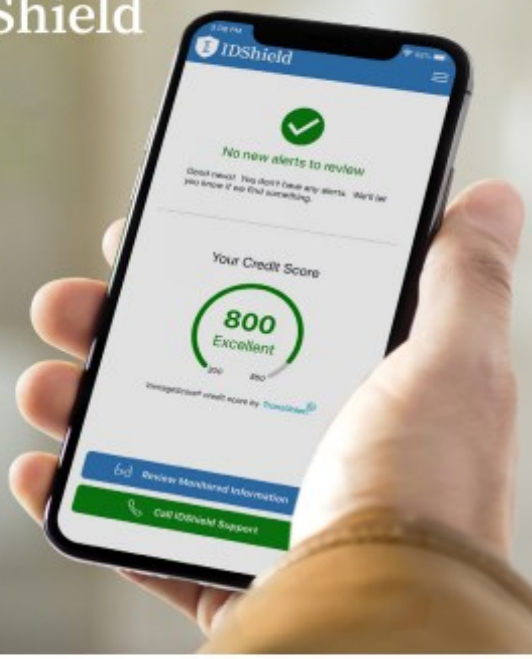
You can also purchase affordable identity theft and privacy protection for either yourself or your family through ID Shield.

ID Shield alerts you to potential theft and fraud with your personal information and then works with you to resolve it.

DID YOU KNOW? Tatonka Education Services provides you with Basic Life and AD&D AT NO CHARGE.

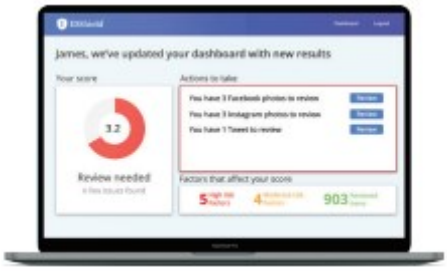
IDShield

Comprehensive Coverage. Direct Access.
Easy to Use Services. Affordable Solution.



Identity Theft and Privacy Protection

Protect your identity and privacy while giving yourself peace of mind.



NEW! IDShield helps **protect your online privacy and reputation** with an **online reputation score tracker**.

IDShield Plan Benefits Include:

360° Degree Protection
IDShield monitors your identity, credit, financial accounts, social media accounts, and provides online privacy reputation management services.

Real-Time Alerts
If a threat is detected to your identity or credit you will receive an alert. You can view your alerts on the IDShield mobile app, member portal and receive them by email.

Full-Service Restoration and Unlimited Consultation
If your identity is stolen IDShield provides you direct access to a dedicated Licensed Private Investigator, who will restore your identity to its pre-theft status, guaranteed. You can also talk to an identity theft specialist about any identity theft or online privacy concern. In the event of an emergency, IDShield provides 24/7 emergency assistance.

Financial Protection
Financial account monitoring and a $1 Million Identity Fraud Protection Plan for unauthorized electronic fund transfers and identity theft related expenses.

Mobile App
The IDShield mobile app makes it easy for you to protect your identity and privacy and track your credit score with IDShield's monthly credit score tracker.

AFFORDABLE IDENTITY AND PRIVACY PROTECTION

INDIVIDUAL	FAMILY
$8.45	$15.95
Per Month	Per Month

FOR MORE INFORMATION, VISIT

benefits.legalshield.com/tatonka

"When I spoke with my investigator, she was very caring and understanding about my situation and helped me tremendously. I feel like a huge weight has been lifted off my shoulders."

K.C. - IDShield Member

DISABILITY INSURANCE

SHORT-TERM DISABILITY INSURANCE

Short-Term Disability insurance is offered through Equitable. **The employee pays 100% of the premium cost as this is a voluntary product.** The plan benefit is 60% of weekly salary up to a maximum benefit of $1,000 per week.

Benefits are paid after a waiting period of 7 days for an accident and 7 days for sickness. Benefits can continue for up to 12 weeks.

LONG-TERM DISABILITY INSURANCE

Long-Term Disability insurance is offered through Equitable. **The employee pays 100% of the premium cost as this is a voluntary product.** The plan benefit is 60% of monthly salary up to a maximum benefit of $5,000 per month.

The benefits begin after a 90 day waiting period. Benefits can continue up to the Social Security Normal Retirement Age.

VOLUNTARY ACCIDENT INSURANCE

Voluntary Accident Insurance is offered through UNUM. Voluntary accident insurance provides a range of fixed, lump-sum benefits for injuries resulting from a covered accident, or for accidental death and dismemberment. These benefits are paid directly to the insured and may be used for any reason, from deductibles and prescriptions to transportation and childcare. This benefit is offered to eligible employees and their dependents, but employees must be insured in order for dependents to be covered. Dependents include your legal spouse or domestic partner, and child(ren) from birth to 26 years old.

Voluntary Critical Illness Insurance

Critical Illness Insurance is offered through UNUM. Voluntary critical illness insurance provides a fixed, lump-sum benefit upon diagnosis of a critical illness, which can include heart attack, stroke, paralysis and more. These benefits are paid directly to the insured and may be used for any reason, from deductibles and prescriptions to transportation and child care. This benefit is offered to eligible employees and their dependents, but employees must be insured in order for dependents to be covered. Dependents include your legal spouse or domestic partner, and child(ren) from birth to 26 years old. Employees can select a coverage amount of either $15,000 or $30,000. Spouses and Dependent child(ren) can select a coverage amount of 50% of the approved employee amount.

Employees are responsible for 100% of the cost of Voluntary Accident Insurance and Voluntary Critical Illness Insurance. The Ease online platform will automatically calculate the cost of this election as well as a detailed benefit summary for your review.

5. REVIEW YOUR DISABILITY COVERAGE

- SHORT-TERM DISABILITY
- LONG-TERM DISABILITY

IMPORTANT NOTE:

If you do not enroll in the STD or LTD plan during your initial enrollment period, you will be required to complete an Evidence of Insurability form and it must be approved by Equitable before you are able to get the coverage in the future.

Nearly **70%** of workers that apply to Social Security Disability Insurance **are denied.**

VIDEO RESOURCES

CLICK THE BELOW LINKS TO LEAR MORE ABOUT CORE EMPLOYEE BENEFIT TERMS AND CONCEPTS:

MEDICAL PLANS

- Medical Plans Explained
- Primary Care vs. Urgent Care vs. ER
- PPO Overview

INSURANCE 101

- Benefits Key Terms Explained
- How To Read An EOB
- What Is A Qualifying Event?

TAX ADVANTAGE SAVINGS ACCOUNTS

- What Is A Flexible Spending Account?

ANCILLARY BENEFITS

- What Is Dental Insurance?
- What Is Vision Insurance?
- What Is Life And AD&D Insurance?
- What Is Accident Insurance?
- What Is Critical Illness Insurance?

GLOSSARY OF MEDICAL TERMS

INSURANCE TERMS

Coinsurance—The plan's share of the cost of covered services which is calculated as a percentage of the allowed amount. This percentage is applied after the deductible has been met. You pay any remaining percentage of the cost until the out-of-pocket maximum is met. Coinsurance percentages will be different between in-network and non-network services.

Copays—A fixed amount you pay for a covered health care service. Copays can apply to office visits, urgent care or emergency room services. Copays will not satisfy any part of the deductible. Copays should not apply to any preventive services.

Deductible—The amount of money you pay before services are covered. Services subject to the deductible will not be covered until it has been fully met. It does not apply to any preventive services, as required under the Affordable Care Act.

Lifetime Benefit Maximum—All plans are required to have an unlimited lifetime maximum.

Network Provider—A provider who has a contract with your health insurer or plan to provide services at set fees. These contracted fees are usually lower than the provider's normal fees for services.

Out-of-pocket Maximum—The most you will pay during a set period of time before your health insurance begins to pay 100% of the allowed amount. The deductible, coinsurance and copays are included in the out-of-pocket maximum.

Preauthorization—A process by your health insurer or plan to determine if any service, treatment plan, prescription drug or durable medical equipment is medically necessary. This is sometimes called prior authorization, prior approval or precertification.

UCR (Usual, Customary and Reasonable)—The amount paid for medical services in a geographic area based on what providers in the area usually charge for the same or similar service.

MEDICAL TERMS

Prescription Drugs—Each plan offers its own unique prescription drug program. Specific copays apply to each tier and a medical plan can have one to five separate tiers. The retail pharmacy benefit offers a 30-day supply. Mail order prescriptions provide up to a 90-day supply. Sometimes the deductible must be satisfied before copays are applied.

Urgent Care—Care for an illness, injury or condition serious enough that a reasonable person would seek immediate care, but not so severe to require emergency room care.

Emergency Room—Services you receive from a hospital for any serious condition requiring immediate care.

Preventive Services—All services coded as Preventive must be covered 100% without a deductible, coinsurance or copayments.

Medically Necessary—Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, which meet accepted standards of medicine.

IMPORTANT NOTICES

WOMEN'S HEALTH & 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 at all stages of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact Samantha Arndt at (720) 475-1056

IMPORTANT INFORMATION REGARDING 1095 FORMS

50+ size groups

As an employer with 50 or more full-time employees, we are required to provide 1095-C forms to each employee who was employed as a full-time employee for at least one month during the calendar year, without regard to whether he/she was covered by our group health plan. These employees should expect to receive their Form 1095-C in early March 2023. We are also required to send a copy of your 1095-C form to the IRS.

The information reported on Form 1095-C is used in determining whether an employer owes a payment under the employer shared responsibility provisions under section 4980H. Form 1095-C is also used by you and the IRS to determine eligibility for the premium tax credit.

SPECIAL ENROLLMENT NOTICE

During the open enrollment period, eligible employees are given the opportunity to enroll themselves and dependents into our group health plans.

If you elect to decline coverage because you are covered under an individual health plan or a group health plan through your parent's or spouse's employer, you may be able to enroll yourself and your dependents in this plan if you and/or your dependents lose eligibility for that other coverage. You must request enrollment within 30 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll any new dependent within 30 days of the event.

If you or your dependents become ineligible for Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

If you or your dependents become eligible for premium assistance from Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

To request special enrollment or obtain more information, contact Human Resources.

NOTICE OF MATERIAL CHANGE (ALSO MATERIAL REDUCTION IN BENEFITS)

Tatonka Education Services has amended the Medical, Dental and Vision benefit plans. This benefit guide contains a summary of the modifications that were made. It should be read in conjunction with the Summary Plan Description or Certificate of Coverage, which is available to you once it has been updated by the carriers. If you would like a copy, please submit your request to Human Resources.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personally identifiable health information. Although Tatonka Education Services may use aggregate information it collects to design a program based on identified health risks in the workplace, the health plan will never disclose any of your personal health information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individuals who will receive your personally identifiable health information are health professionals in order to provide you with services under the wellness program.

IMPORTANT NOTICES

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Samantha Arndt at (720) 475-1056

INITIAL COBRA NOTICE

For new hires or new benefits eligible only

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

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

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

IMPORTANT NOTICES

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Samantha Arndt

How is COBRA continuation coverage provided?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage -

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

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage.

If you have questions -

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes -

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information -

Samantha Arndt

(720) 475-1056

sarndt@tatonkaeducation.org

This notice is intended as a brief outline; please see HR for more information.

IMPORTANT NOTICES

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment ProgramWebsite: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery. com/hipp/index.html Phone: 1-877-357-3268

IMPORTANT NOTICES

GEORGIA-Medicaid	MAINE-Medicaid
A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization- act-2009-chipra Phone: (678) 564-1162, Press 2	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711
INDIANA-Medicaid	**MASSACHUSETTS-Medicaid and CHIP**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840
IOWA-Medicaid and CHIP (Hawki)	**MINNESOTA-Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://mn.gov/dhs/people-we-serve/children-and- families/health-care/health-care-programs/programs-and- services/other-insurance.jsp Phone: 1-800-657-3739
KANSAS-Medicaid	**MISSOURI-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY-Medicaid	**MONTANA-Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
LOUISIANA-Medicaid	**NEBRASKA-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)	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

IMPORTANT NOTICES

NEVADA-Medicaid	SOUTH CAROLINA-Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE-Medicaid	**SOUTH DAKOTA-Medicaid**
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY-Medicaid and CHIP	**TEXAS-Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA-Medicaid	**VERMONT-Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA-Medicaid	**VIRGINIA-Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OKLAHOMA-Medicaid and CHIP	**WASHINGTON-Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
OREGON-Medicaid	**WEST VIRGINIA-Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	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)
PENNSYLVANIA-Medicaid	**WISCONSIN-Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP- Program.aspx Phone: 1-800-692-7462	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
RHODE ISLAND-Medicaid and CHIP	**WYOMING-Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

IMPORTANT NOTICES

To see if any other states have added a premium assistance program since January 31, 2022, or for more information onspecial 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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)