CENTRAL MINNESOTA
CMMHC
MENTAL HEALTH CENTER











If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.
Please see page 31 for more details.

2026 Benefit Guide

Table of Contents

This brochure summarizes the benefit plans that are available to Central Minnesota Mental Health Center eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.

A Message to Our Employees

The Benefits Open Enrollment Period Is Here!

At Central Minnesota Mental Health Center, we know how important it is to have comprehensive, affordable health benefits. That's why we offer competitive plans that can provide protection, peace of mind, and savings.

2026 Benefit Plan Highlights

The medical plan will be renewing with Medica for 2026. We will be adding a copay plan as a second option.

Due to IRS regulations the medical plan Deductibles and Out-of-Pocket Maximums have increased, see comparison below:

Benefit Coverage	Medica Choice Passport HSA Plan			
	In-Network Benefits		Out-of-Network Benefits	
Annual Deductible	**2025**	**2026**	**2025**	**2026**
Individual	$3,300	$3,400	$6,600	$6,600
Family	$6,600	$6,800	$13,200	$13,200
Maximum Out-of-Pocket*				
Individual	$3,300	$3,400	$10,000	$10,000
Family	$6,600	$6,800	$20,000	$20,000

Benefits for You & Your Family

CMMHC is pleased to announce our 2026 benefits program, which is designed to help you stay healthy, feel secure, and maintain a work/life balance. Offering a competitive benefits package is just one way we strive to provide our employees with a rewarding workplace. Please read the information provided in this guide carefully. For full details about our plans, please refer to the summary plan descriptions. Listed below are the CMMHC benefits available during open enrollment:

Medical
Nice Healthcare
Proximal Health
Dental
Vision
Basic Life and AD&D
Voluntary Life and AD&D
Short Term Disability
Long Term Disability
Worksite Benefits
Health Savings Account
Flexible Spending Accounts

Who is Eligible?

Employees working an average of 60 hours per pay period are generally eligible for medical, dental, vision, life and disability coverage. Employees working an average of 36 - 40 hours per week will be eligible for medical, dental, life and disability benefits equal to the standard CMMHC contribution. Employees who work an average of 30-35 hours per week will be eligible for medical, dental, life and disability benefits on a pro-rated basis to the standard CMMHC contribution.

Generally, for the CMMHC benefits program, dependents are defined as:

- Your spouse
- Dependent "child" up to age 26.
  (Child means the employee's natural or adopted child, stepchild and any other child as defined in the certificate of coverage)

When and How Do I Enroll?

You will have 30 days from your start date to enroll in benefits.

All eligible employees are required to complete the enrollment process, even if you do not wish to make any changes to your benefits.

When is My Coverage Effective?

The effective date for your benefits is the 1st of the month following 30 days of hire.

Changing Coverage During the Year

You can change your coverage during the year when you experience a qualified change in status, such as marriage, divorce, birth, adoption, placement for adoption, or loss of coverage. The change must be reported to the Human Resources Department within 30 days of the event. The change must be consistent with the event.

For example, if your dependent child no longer meets eligibility requirements, you can drop coverage only for that dependent.

Medical Plan

CMMHC will continue to offer a medical plan through Medica Insurance Company. The chart below is a brief outline of the plan. Please refer to the summary plan description for complete plan details.

Benefit Coverage	Medica Choice Passport - $3,400-100% Plan In-Network Benefits	NEW - Medica Choice Passport - $750-$45-75% In-Network Benefits
Annual Deductible		
Individual	$3,400	$750
Family	$6,800	$2,250
Maximum Out-of-Pocket*		
Individual	$3,400	$3,500
Family	$6,800	$7,000
Physician Services		
Primary Care Office Visit	You pay nothing after deductible	$45 copay
Nice Healthcare	No copay	No copay
Specialty Care Office Visit	You pay nothing after deductible	$45 copay
Other Physician/Surgeon Fees	You pay nothing after deductible	You pay 25% after deductible
Preventive Care		
Adult Periodic Exams	You pay nothing	You pay nothing
Well-Child Care	You pay nothing	You pay nothing
Diagnostic and Facility Services		
Laboratory Services	You pay nothing after deductible	You pay nothing
X-ray & Other Imaging Services	You pay nothing after deductible	You pay 25% after deductible
Urgent Care Facility	You pay nothing after deductible	$45 copay
Emergency Room	You pay nothing after deductible	You pay 25% after deductible
Inpatient/Outpatient Facility	You pay nothing after deductible	You pay 25% after deductible
Mental Health/Substance Abuse		
Inpatient	You pay nothing after deductible	You pay 25% after deductible
Outpatient	You pay nothing after deductible	$45 copay
Other Services		
Chiropractic	You pay nothing after deductible	$45 copay
Durable Medical Equipment	You pay nothing after deductible	You pay 25% after deductible
Home Health Care	You pay nothing after deductible	You pay 25% after deductible
Retail Pharmacy (31 Day Supply)		
Designated Preventive Drugs	You pay nothing	n/a
Generic Drugs	You pay nothing after deductible	$12 copay
Preferred Brand Drugs	You pay nothing after deductible	$50 copay
Non-Preferred Brand Drugs	You pay nothing after deductible	$90 copay
Specialty Drugs	You pay nothing after deductible	20% after deductible up to $200 copay/Rx

Monthly Employee Contributions – $3,400-0% HSA Medical Plan			
Coverage Tier	**Total Premium**	**Full-Time (36-40 hrs/wk) Employee Cost**	**Part-Time (30-35 hrs/wk) Employee Cost**
Employee only	$1,140.25	$70.70	$229.57
Employee + Spouse	$1,950.93	$740.11	$898.99
Employee + Child(ren)	$1,702.66	$421.69	$603.24
Family	$2,255.99	$878.61	$1,060.16

Monthly Employee Contributions – $750-$45-25% Medical Plan			
Coverage Tier	**Total Premium**	**Full-Time (36-40 hrs/wk) Employee Cost**	**Part-Time (30-35 hrs/wk) Employee Cost**
Employee only	$1,264.39	$194.84	$353.71
Employee + Spouse	$2,163.33	$952.51	$1,111.39
Employee + Child(ren)	$1,888.03	$607.06	$788.61
Family	$2,501.60	$1,124.22	$1,305.77

Important Note: An additional $39.00 per month will be deducted from the pay of employees enrolling in the CMMHC health plan to cover the cost of the Nice Healthcare program. The rates above have been reduced by this amount so that the net cost to employees for the Nice program is the taxes. Employees must pay the taxes on this program cost for the plan to remain compliant with IRS regulations.

Medica Choice® Passport Network

The Medica Choice® Passport Network provides access to a large, national network with over 7,300 hospitals and 1,500,000 physicians. Since it is an open access network, referrals are not needed to see a specialist – you can see any provider at any time.

To search the provider network login to the Medica member portal or:

1. Go to www.medica.com
2. Select *Search Our Network* under **Find Care** in the menu bar at the top of the page
3. Scroll down to the **OUR PLANS** section and click on *Employer-provided*
4. Click on *Find a Physician or Facility* in the menu on the left
5. Click on *Medica Choice Passport with UnitedHealthcare Choice Plus* in the list of links

Medica Support Resources

24-Hour Health Support

Trusted answers any time of day or night. Worried that your stomach bug could be serious? Wondering what to do about that cough that won't go away? The advisors and nurses at Medica CallLink® can help. They're available 24 hours a day, 365 days a year to answer your questions and help you make smart decisions about your health. Just call **1 (800) 962-9497** (TTY users, call **711**).

Behavioral Health Support

Manage stress, anxiety and depression symptoms. Connect with on-demand help for stress, depression and anxiety through the Sanvello app. Access coping tools, daily mood tracking, guided journeys, and weekly progress check-ins to stay engaged and manage symptoms. You receive premium access as part of your plan's behavioral health benefits. Download the Sanvello app from the App Store or Google Play and select *Upgrade Through Your Insurance* to get started.

Medica Value Adds

Your plan includes extras to help you stay healthy, get support, and make the most of your plan — at no extra cost to you.

Stay healthy

Health rewards program

Get inspired to make positive changes. Taking steps to improve your health might be easier than you think. Want to lower your stress? Quit smoking? Eat more fruit and veggies? My Health Rewards by Medica® makes it fun — and rewarding. You'll earn rewards as you complete activities personalized just for you. Starting Jan. 1, download the Personify Health app (formerly Virgin Pulse), free in the App Store and on Google Play.

Omada for Prevention

Build healthy habits that last. Help reduce your risk for chronic disease through Omada for Prevention.* Combining the latest technology with ongoing personal support, you can make changes around eating, activity, sleep, or stress. It's an approach that can help you lose weight, feel great, and develop long-term healthy habits. If you or your adult dependents are at risk for Type 2 diabetes or heart disease and enrolled in a Medica health plan, Omada is available at no additional cost. Take a quick online health assessment to see if you're eligible at **OmadaHealth.com/Medica.**

Personalized family + women's health program

Access live and tailored 1:1 support for every journey. Ovia Health is here to guide and support you through all of life's moments: From cycle tracking and trying to conceive, to pregnancy, parenting, and managing perimenopause and menopause. Get clinically-backed content and unlimited support from Ovia's Care Team of health coaches, registered nurses, nutritionists, and certified nurse midwives. Sign in to your member account to learn more about the Ovia apps and enroll at no cost: **Medica.com/SignIn**.

Medica®

Get support

24-hour health support

Trusted answers day or night. Worried your stomach bug could be serious? Or about that cough that won't go away? The nurse advisors at Medica CallLink® can help. They're available 24/7/365 to answer questions and help you make smart health decisions. Just call **1 (800) 962-9497** (TTY: **711**).

Behavioral health support

On-demand help for stress and emotional well-being. Access self-care techniques, coping tools, meditations, sleep tracking, and more at no additional cost to you — anytime, anywhere with Self Care by AbleTo. Check in, track your progress, and explore personalized content that you can move through at your own pace on your mobile device. Build skills you can use for life to feel better. To get started, visit **AbleTo.com/Begin** and enter "Medica" when asked for your access code. After you register, download the AbleTo app.

Employee assistance program

Get help with life's challenges. Whether it's financial troubles, personal issues, or family problems, Medica® Optum® Emotional Wellbeing Solutions can help. Call **1 (800) 626-7944** (TTY: **711**) 24/7/365 to talk with a specialist. They'll help you find resources and can connect you to no-cost, short-term counseling visits with a therapist, or consultations for financial and legal support, to get back on track.

Find information

Your digital one-stop health plan resource

Manage your plan from any device, any time. With your member account, you can:

- Download and print your ID card and order extras
- Find health care and virtual care providers, clinics, and pharmacies in your network
- Track your medical claims and prescription drugs
- Check medical procedure and drug costs
- See what your plan covers and find out your share of the costs
- Explore wellness programs and behavioral health resources

Create an account at **Medica.com/SignIn** or search for the "Medica Member" app in the App Store or Google Play to manage your health plan benefits and improve your health on-the-go.

Have questions? We're here to help.

Call Member Services at the number on the back of your Medica ID card (TTY: **711**) or find answers to commonly asked questions in your member account at **Medica.com/SignIn**.

*Omada is not available with all Medica health plans. To check if you are eligible for this benefit, call Medica Member Services. The number is on the back of your ID card.

Medica®

Proximal Health

Top doctors and extra benefits

Proximal Health is a service that will help you when you need to find a top doctor and that will pay you up to $1,500 if your condition turns into something serious such as hospitalization or cancer. These benefits are paid on top of the benefits you receive through your medical plan. You can use these benefits for any expense.

Who can use Proximal?

Employees (and their covered dependents) who are enrolled in the medical plan are covered by the Proximal plan.

What services does Proximal cover?

Benefits are available for three types of specialty care:

- Hospitalization
- Cancer
- Maternity

Using Proximal is as easy as 1-2-3

1. Find a Designated Physician at proximal.com
2. Get hospital, cancer or maternity care
3. Upload your bill at proximal.com

Designated Physicians are expert doctors who are in the health plan network. They have been chosen by Proximal as the top doctors who specialize in your condition and earn high marks in independent quality reviews.

What are the benefits?

If you use a Proximal Designated Provider, the benefit is $1,500. An extra $500 transportation benefit is available if the covered event occurs more than 100 miles from home.

If you use a non-Designated provider, the benefit is $300. There is no transportation benefit available when using non-Designated providers.

To contact Proximal:

- Scan the QR Code, or
- Go to www.proximal.com
- Email support@proximal.com
- Call 612-453-2199

Nice Healthcare

Nice Healthcare is an employer-sponsored benefit that offers you and your dependents currently enrolled in the medical plan, a variety of **in-home and primary care services**.

Virtual Chat and Video Visits

Using the Nice Healthcare app, Nice offers same-day chat or video visits with licensed clinicians who can diagnose conditions, refer you for additional services provided by Nice, or refer you to a specialist. Virtual visits may last up to 45 minutes. All Nice services are started with a virtual visit with your Nice clinician.

In-Home Visits with Clinicians

When virtual visits don't meet your needs, Nice will send one of their licensed clinicians to your home or workplace to conduct physical tests, labs and blood draws, and address any concerns you may have. In-home visits usually occur the same day, or the day after they're requested depending on the patient's needs. Clinicians are given up to 45 minutes with each patient.

Imaging Services

Nice can send imaging technicians to your home to conduct X-rays and EKG services. Imaging services may be scheduled in as little as 4 hours after your initial virtual visit with your clinician. If you can't wait that long, please seek emergency or urgent care services.

550+ Free Medications

Nice offers you over 550 medications with no out-of-pocket costs. Your clinician can send a prescription to your choice of over 60,000 pharmacies nationwide, excluding Walgreens. So, all you need to do is show up, present your Nice Rx card in the app, and get the medication you need without worrying about the cost.

Virtual Physical Therapy

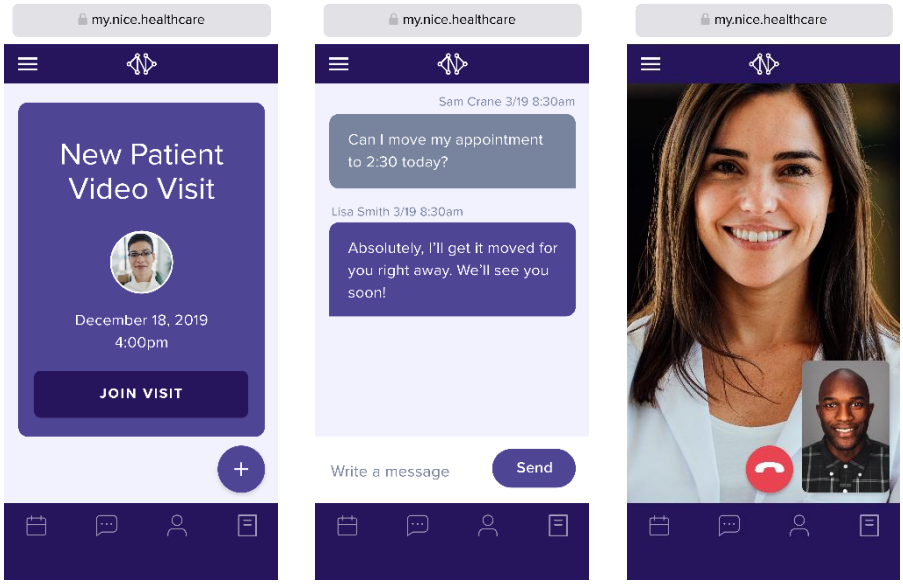
Patients with musculoskeletal issues or concerns may receive access to licensed physical therapists through the Nice app. Initial evaluations are 60 minutes and will determine your treatment plan and follow-up needs. Patients must consult their Nice clinician to enroll in physical therapy.

Virtual Mental Health Therapy

Nice offers patients access to licensed mental health therapists to address a wide range of behavioral health issues through virtual sessions in the Nice app. Initial consultations are 90 minutes and follow-up sessions will last up to 60 minutes.

HOW TO SCHEDULE A NICE VISIT

1. Download the Nice Healthcare app using the QR code to the left or searching for “Nice Healthcare” in your app store. You may also create an account online at www.nice.healthcare/schedule.
2. Open the Nice app and click ”Sign Up”. You’ll be asked to create an account. This should only take a few minutes.
   - Each adult is required to have a separate account. Children can be added under the parent/primary account holder.
3. Click “Book Appointment” and follow the prompts to schedule your first visit. This will take 15-20 minutes, though future visits will take you no more than five minutes.
4. You will receive email and push notifications as your appointment nears. When it’s time for your virtual visit, log in to your account and click “Join Visit” to begin.



WHERE DOES NICE OPERATE?

To see an interactive map of where Nice’s full suite of services are offered, use the QR code to the right or visit their Locations page at www.nice.healthcare/locations.

WHAT IS NICE?

Nice Healthcare is a primary care clinic that offers you and your dependents virtual visits with licensed clinicians.

WHAT’S INCLUDED

- Chat and video visits with a clinician
- In-home primary care visits, including:
  - 35 free labs (blood draws)
  - Free X-rays
  - Free physical tests
- 550+ free medications
- Free virtual physical therapy
- Free virtual mental health therapy

WHO CAN USE NICE?

- Any employee of CMMHC who is enrolled in the company health plan
- Benefit eligible dependent of the employee as defined by the employer who are enrolled in the medical plan. Other residents of the employee’s home are not eligible for Nice.
- Benefit eligible employees over age 65 are also eligible for this.

NICE HEALTHCARE HOURS

Virtual Visit Hours (CST)

Monday - Friday 8AM - 7PM
Saturday - Sunday 9AM - 12PM

Home Visit Hours (Local Time)

Monday - Friday 9AM - 5PM

Dental Plan

CMMHC will continue to offer a dental plan through Delta Dental of Minnesota. The chart below is a brief outline of the plan. Please refer to the summary plan description for complete plan details.

Dental Benefit Coverage	Delta Dental Plan	
	Delta Dental PPO or Premier Providers	Out-of-Network Providers
Annual Deductible		
Deductible	$50 per person; $150 per family	
Annual Maximum Benefit		
Per Person	$1,000	
Diagnostic & Preventive Services		
Exams, cleanings, x-rays, fluoride, space maintainers, sealants	You pay $0 (deductible waived)	You pay $0 (deductible waived)*
Basic Restorative Care		
Emergency pain treatment, amalgam restorations (silver), composite resin restorations (white fillings) on anterior (front) teeth Composite restorations on posterior (back) teeth limited to the allowance of amalgam fillings	You pay 20% after deductible	You pay 20% after deductible*
Endodontic Therapy		
Pulpotomies on primary teeth, root canal therapy	You pay 20% after deductible	You pay 20% after deductible*
Periodontics		
Surgical and non-surgical periodontics	You pay 20% after deductible	You pay 20% after deductible*
Oral Surgery		
Surgical and non-surgical extractions, all other oral surgery	You pay 20% after deductible	You pay 20% after deductible*
Major Restoratives		
Crowns, composite restorations	You pay 50% after deductible	You pay 50% after deductible*
Prosthetics / Prosthetic Repairs		
Dentures, bridges, limited implant coverage	You pay 50% after deductible	You pay 50% after deductible*

**Dentists who have signed a participating network agreement with Delta Dental have agreed to accept the maximum allowable fee as payment in full. Non-participating dentists have not signed an agreement and are not obligated to limit the amount they charge; the member is responsible for paying any difference to the non-participating dentists.*

Monthly Employee Contributions – Dental Plan			
Coverage Tier	**Total Premium**	**Full-Time (36-40 hrs/wk) Employee Cost**	**Part-Time (30-35 hrs/wk) Employee Cost**
Employee only	$32.02	$0.00	$5.48
Employee + Spouse	$56.67	$23.68	$29.16
Employee + Child(ren)	$74.67	$32.63	$38.11
Family	$99.32	$56.29	$61.77

Vision Insurance

CMMHC offers Vision Insurance through EyeMed.

Vision Benefit Coverage	EyeMed Vision Plan (Insight Network)	
Vision Care Services	**In-Network Member Cost**	**Out-of-Network Reimbursement**
Standard Plastic Lenses		
Single Vision	$20 copay	Up to $30
Bifocal	$20 copay	Up to $50
Trifocal	$20 copay	Up to $70
Lenticular	$20 copay	Up to $70
Standard Progressive	$85 copay	Up to $50
Premium Progressive	$105 - $130	
Tier 1	$105	Up to $50
Tier 2	$115	Up to $50
Tier 3	$130	Up to $50
Tier 4	$85, 80% of charge less $120 allowance	Up to $50
Contacts		
Conventional	$0 copay; $130 allowance;15% off balance over $130	Up to $130
Disposable	$0 copay; $130 allowance; plus balance over $130	Up to $130
Medically Necessary	$0 copay; paid in full	Up to $210
Frames	$0 copay; $130 allowance; 80% of charge over $130	Up to $91
Frequencies		
Lenses or Contact Lenses	Once every 12 months	
Frames	Once every 24 months	
Lens Options (paid by member and added to the base price of the lens)		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate	$40	N/A
Anti-Reflective Coating	$45 - $68 or 20% off retail price	N/A
Photochromic/Transitions	$75	N/A
Polarized and Other Add-Ons	20% off retail price	N/A

Monthly Employee Contributions – Vision Plan	
Coverage Tier	**Employee Cost**
Employee only	$4.72
Employee + Spouse	$8.97
Employee + Child(ren)	$9.44
Family	$13.87

Basic Life and AD&D Insurance

CMMHC provides each benefits-eligible employee with coverage under a Basic Life and Accidental Death and Dismemberment (AD&D) policy. The benefit amount is one time your annual earnings up to a $50,000 maximum. CMMHC pays the premiums for this coverage.

The Life insurance benefit will be paid to your designated beneficiary in the event of death while covered under the plan. The AD&D benefit will be paid in the event of a loss of life or limb by accident while covered under the plan.

**Life and AD&D benefits will reduce by 35% at age 65 and 50% of original amount at age 70.*

Voluntary Life and AD&D Insurance

In addition to the employer paid Basic Life and AD&D coverage, you have the option to purchase additional voluntary life and AD&D insurance to cover any gaps in your existing coverage that may be a result of age reduction schedules, cost of living, existing financial obligations, etc. If you elect coverage for yourself, you may also buy coverage for your spouse and/or children. Employees pay the premiums for this coverage.

Employee coverage is available in increments of $10,000 up to a maximum of 5 times your annual earnings or $500,000, whichever is less. When you first become eligible for this coverage there is a guaranteed issue amount of $150,000.

Spouse coverage is available in $5,000 increments up to a maximum of $250,000 or 50% of the employee amount, whichever is less. A guaranteed issue amount of $25,000 is available if coverage is elected when first eligible.

Coverage for children is available in the following options. Options are $1,000, $2,000, $4,000, $5,000 or $10,000. Children from 15 days but not yet age 6 months are limited to a reduced benefit of $1,000.

Evidence of insurability is required for late enrollees, benefit increases and amount over the guaranteed issue amount, if applicable. No evidence of insurability is required for child coverage.

Voluntary life and AD&D are sold as a package. If you elect coverage under this plan, you will be enrolled in coverage in both at the same amount.

Voluntary Life and AD&D Insurance Rates

Your premiums are based on the member's age and the amount of coverage elected.

Monthly Voluntary Life Rates		
Age	**Employee**	**Spouse***
	All rates are per $1,000 in Coverage	
Less than 30	$0.073	$0.072
30-34	$0.083	$0.098
35-39	$0.126	$0.098
40-44	$0.174	$0.124
45-49	$0.301	$0.150
50-54	$0.541	$0.228
55-59	$0.933	$0.332
60-64	$1.340	$0.592
65-69	$2.220	$1.086
70+	$3.430	$1.086

***Spouse premium based on employee's age.**

Child(ren)	$0.285 per $1,000 in coverage

Voluntary AD&D	Employee	Spouse	Child(ren)
Monthly Premium per $1,000 in Coverage	$0.02	$0.02	$0.02

Paid Family and Medical Leave

Starting January 1, 2026, Minnesota Paid Leave will offer payments and job protection to people who need time away from work for their own health or to care for a family member. Paid Leave helps Minnesotans stay financially stable while caring for their own well-being or being there for a loved one.

When can I use Paid Leave?

You can take Minnesota Paid Leave for medical or family reasons.

Medical Leave

- Take care of yourself for a serious health condition. A serious health condition means a physical or mental illness, injury, impairment, condition, or substance use disorder. Taking care of yourself for this serious condition may involve evaluation, treatment, inpatient care, recovery, or not being able to perform regular work, attend school, or do regular daily activities. This includes childbirth, conditions related to pregnancy, or surgery.

Family Leave

- Bonding leave – Care for and bond with a new child welcomed through birth, adoption, or foster placement.
- Caring leave – Care for a family member with a serious health condition.
- Military family leave – Support a family member called to active duty.
- Safety leave – To respond to issues such as domestic violence, sexual assault, or stalking.

How much time can I take?

In a single benefit year, you may take up to:

- 12 weeks of Medical Leave
- 12 weeks of Family Leave

If you qualify for both leave types, you can take a combined maximum of 20 weeks in one benefit year. Your benefit year starts the first day you take leave.

Each leave requires certification from a health care provider or service provider.

How much does coverage cost?

Employees are responsible for $.44 per $100 covered earnings up to the FICA limit.

Please contact MetLife for more information.

Short-Term Disability Insurance

Benefit eligible employees are automatically covered under the company's short term disability plan. CMMHC pays 100% of the premiums for this coverage.

Benefits begin on the 8th day of disability. The benefit is 60% of pre-disability earnings up to a $1,000 maximum benefit per week. Benefits continue until you are no longer disabled, or the maximum benefit period of 12 weeks is reached. Please see the policy document for additional information.

Long-Term Disability Insurance

CMMHC provides benefits-eligible employees with long-term income protection at no cost. This plan replaces a portion of your income if you become disabled and are unable to work due to a non-work-related illness or injury.

The benefit is 60% of your earnings to a maximum monthly benefit of $3,000. Benefit payments begin after 90 days of disability. If you become disabled prior to age 63, benefits may continue for as long as you remain disabled or until the greater of your Social Security normal retirement age or 4 years. If your disability occurs at age 63 or above, the number of payments may reduce.

Please see the summary plan description for complete plan details.

Worksite Benefits with MetLife

These benefits are voluntary and paid for by the employee with post-tax premium contributions. Because the premiums are paid post-tax the benefits received are non-taxable.

CRITICAL ILLNESS BENEFIT PLAN

Critical Illness is a limited benefit meaning that it is not health insurance and there are no copays or reimbursements for services. Critical Illness pays a benefit on top of any health insurance benefits you receive. Critical Illness pays you a one-time, lump sum benefit amount upon diagnosis of a covered disease or illness. These dollars can be used to help cover expenses not covered by the medical plan: to pay your deductible, childcare, travel, home health costs, expenses, etc. Covered diseases/illness include heart attack, stroke, end stage renal (kidney) failure, coronary artery bypass (25% of max benefit), coma, major organ failure, permanent paralysis, cancer, carcinoma in situ (25% of max benefit), and skin cancer (10% of max benefit). This benefit is provided by MetLife.

ACCIDENT INSURANCE PLAN

Accident insurance pays a specified amount, on top of any health insurance benefits you receive, for specific injuries resulting from a covered accident. You can use the money however you need it: medical expenses, childcare, groceries, utilities, etc.

The benefit amounts vary based on the nature of the injury. Examples of covered injuries are surgery, loss of limb, burns, laceration requiring sutures, joint injuries, dislocated/broken bones, etc. This benefit is provided by MetLife.

VOLUNTARY HOSPITAL INDEMNITY PLAN

A hospital indemnity plan can complement your medical coverage by helping ease the financial impact of a hospitalization. The benefit can be used however you choose, for example, to help offset your medical plan deductible/coinsurance or to cover lost time from work. This plan provides a lump sum benefit for eligible hospital confinements. The benefit will pay you $1,000 upon a hospital admission and then up to $100 per day to a maximum of 15 days per calendar year. You may purchase this coverage for yourself, your spouse and/or your children up to age 26. In order to elect coverage for your spouse or children you must elect coverage for yourself. This benefit is provided by MetLife.

Flexible Spending Accounts

The Flexible Spending Account (FSA) plan through HR Simplified allows you to set aside pre-tax dollars to cover qualified expenses you would normally pay out of your pocket with post-tax dollars. The plan is comprised of a health care spending account and a dependent care account. You pay no federal or state income taxes on the money you place in an FSA.

How an FSA works:

- Choose a specific amount of money to contribute each pay period, pre-tax, to one or both accounts during the year.
- The amount is automatically deducted from your pay at the same level each pay period.
- As you incur eligible expenses, you may use your flexible spending debit card to pay at the point of service **OR** submit the appropriate paperwork to be reimbursed by the plan.
  (You may be asked to substantiate certain purchases made with the debit card)

Important rules to keep in mind:

- The IRS has a strict "use it or lose it" rule**.** If you do not use the full amount in your FSA, you will lose any remaining funds.
- Once you enroll in the FSA, you cannot change your contribution amount during the year unless you experience a qualifying life event.
- You cannot transfer funds from one FSA to another.

Please plan your FSA contributions carefully, as any funds not used by the end of the year will be forfeited. Re-enrollment is required each year.

Maximum Annual Election	
Health Care FSA	$3,400
Dependent Care FSA	$7,500

Health Savings Account (HSA)

What is a Health Savings Account (HSA)?

An HSA is a tax-sheltered bank account that you own to pay for eligible health care expenses for you and/or your eligible dependents for current or future healthcare expenses. The Health Savings Account (HSA) is yours to keep, even if you change jobs or medical plans. There is no "use it or lose it" rule; your balance carries over year to year.

Plus, you get extra tax advantages with an HSA because:

- Money you deposit into an HSA is exempt from federal income taxes
- Interest in your account grows tax free; and
- You don't pay income taxes on withdrawals used to pay for eligible health expenses. (If you withdraw funds for non-eligible expenses, taxes and penalties apply).

Are you eligible to open a Health Savings Account (HSA)?

You are eligible to open and contribute to an HSA if you meet **all** of the following requirements:

- You are enrolled in a Qualified High Deductible Health Plan (QHDHP)
- You are not be covered by another non-QHDHP health plan, such as a spouse's PPO plan.
- You are not enrolled in Medicare.
- You are not in the TRICARE or TRICARE for Life military benefits program.
- You have not received Veterans Administration (VA) benefits within the past three months.
- You are not claimed as a dependent on another person's tax return.
- You are not covered by a traditional health care flexible spending account (FSA). This includes your spouse's FSA. (Enrollment in a limited purpose health care FSA is allowed).

How do I get reimbursed for my eligible expenses?

The easiest way to use your HSA dollars is by using your HSA debit card at the time you incur an eligible expense. If you pay another way, you can reimburse yourself from your HSA. But keep your receipts! You must be able to prove that you were reimbursing yourself for an eligible expense if you are ever audited. If you use your HSA funds for non-eligible expenses, you will be charged a 20% penalty tax (if under age 65) as well as federal income taxes. You can manage your HSA through www.hellofurther.com 24 hours a day, seven days a week.

2026 Maximum HSA Contributions

	Employee Only Coverage	Employee + Spouse, Employee + Child(ren) or Family Coverage
Maximum HSA Contribution	$4,400	$8,750
CMMHC Contribution	$400	$400
Maximum Employee HSA Contribution	$4,000	$8,350
With Additional $1,000 Allowed for Ages 55+	$5,000	$9,350

Employee Assistance Plan (EAP)

EAP Through MetLife

Life does not always go smoothly. All of us experience times when a personal problem or crisis affects the way we function at work or home. The Employee Assistance Program (EAP) through MetLife is a problem-solving resource available to you at no charge. This program provides access to Master's- and PhD-degreed clinicians for 24/7 assistance. Services include up to 5 telephonic or video conferencing per occurrence per year for financial, legal, and work-life concerns. All calls are completely confidential. No one at work will know you have chosen to seek help unless you choose to tell them. Nothing concerning your use of EAP will appear in your personnel file.

Call 1-888-319-7819 or visit https://metlifeeap.lifeworks.com/life/employee-assistance
Userid: metlifeeap
Password: eap

EAP Reciprocity

CMMHC also participates in a reciprocity arrangement with the facilities listed below to provide complimentary services to CMMHC employees.

- Lakeland Mental Health Center - Fergus Falls - (218) 736-6987
- Northern Pines Mental Health Center - Brainerd/Little Falls - (218) 829-3235
- Northwestern Mental Health Center - Crookston - (218) 281-3940
- Sioux Trails Mental Health Center - New Ulm - (507) 354-3181
- Southwestern Mental Health Center - Luverne - (507) 283-9511
- Western Human Development Center - Marshall - (507) 532-3236
- Woodland Centers - Willmar - (320) 235-4613

403(b) RETIREMENT SAVINGS PLAN

- CMMHC offers the option of a traditional or Roth 403(b) plan.
- To be eligible for the plan you must be at least 18 years old.
- CMMHC has elected in an auto enrollment option for our employees stating that every employee wishes to put 3% of their income into a traditional 403(b) plan. You are automatically enrolled into an estimated retirement age account. This is based off your year of birth.
- NOTE: In a traditional 403(b) funds are placed into the account pre-tax. This means you will have to pay taxes when you withdrawal the funds. In a Roth 403(b) the funds are placed in the account after your check is taxed. This means when you retire all the money is yours.
- As an added benefit, CMMHC contributes 5.5% of your annual salary into a vested 403(b) account at no cost to you. You are required to work here 1 year and work over 1000 hours to begin contributions into the plan.

Vesting Schedule - 403(b) Plan						
Years of Service	1	2	3	4	5	6
Vested Percentage	0%	20%	40%	60%	80%	100%

For more information on the CMMHC 403(b) Retirement Savings Plan, log on to the employee portal at **www.connect2mybenefits.com** or visit **https//participant.empower-retirement.com/participant/#/login.**

HOLIDAYS

Regular full-time employees are eligible for paid time off on holidays.

- New Year's Day
- Memorial Day
- Juneteenth
- Independence Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving
- Christmas Day
- Two (2) Floating Holidays- floating holidays are for staff to take time off for religious or cultural holidays, employee birthdays, or other state or federal holidays during which CMMHC remains open.

PAID TIME OFF (PTO)

Employees Scheduled 36 - 40 hours per work week		
Years of Eligible Service	PTO Days Each Year	PTO Hours Accrued Per Pay Period
0 – 2 Years	22 Days (176 Hours)	6.77 Hours
3 – 4 Years	25 Days (200 Hours)	7.69 Hours
5 – 7 Years	28 Days (224 Hours)	8.62 Hours
8 – 9 Years	30 Days (240 Hours)	9.23 Hours
10+ Years	31 Days (248 Hours)	9.54 Hours

Employees Scheduled 30 - 35 hours per work week		
Years of Eligible Service	PTO Days Each Year	PTO Hours Accrued Per Pay Period
0 – 2 Years	18 Days (141 Hours)	5.42 Hours
3 – 4 Years	20 Days (160 Hours)	6.16 Hours
5 – 7 Years	22 Days (179 Hours)	6.90 Hours
8 – 9 Years	24 Days (192 Hours)	7.39 Hours
10+ Years	25 Days (198 Hours)	7.63 Hours

Contacts

Please contact Human Resources to complete any changes to your benefits that are not related to your initial or annual enrollment.

Carrier Customer Service

BENEFIT PLAN	CARRIER	PHONE NUMBER	WEBSITE
Medical	Medica	(800) 952-3455	www.medica.com
Nice Healthcare	Nice	(763) 412-1993	nice.healthcare
Proximal Health	Proximal	(612) 453-2199	www.proximal.com
Dental	Delta Dental of Minnesota	(800) 448-3815	www.deltadentalmn.org
Vision	EyeMed	(866) 804-0982	www.eyemed.com
Life and AD&D	MetLife	(800) 638-2704	www.metlife.com
Voluntary Life and AD&D	MetLife	(800) 638-2704	www.metlife.com
Paid Family Medical Leave	MetLife	(800) 638-2704	www.metlife.com
Long Term Disability (LTD)	MetLife	(800) 638-2704	www.metlife.com
Critical Illness, Hospital or Cancer	MetLife	(800) 638-2704	www.metlife.com
Health Savings Account	HeathEquity	(866) 382-3510	www.healthequity.com
Flexible Spending Accounts	ChardSnyder	(800) 982-7715	www.chard-snyder.com
Employee Assistance Program (EAP)	MetLife - Lifeworks	(888) 319-7819	www.meteap.lifeworks.com
EAP Reciprocity	See previous page for details.		

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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; and
- 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 ACT DISCLOSURE - FEDERAL

Group health plans and health insurance issuers 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 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 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

CONTACT INFORMATION

CONTACT INFORMATION

Questions regarding any of this information can be directed to:
Brittany Liberty
320-230-0614
bliberty@cmmhc.com

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***Please review it carefully****.*
Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/hipaa/filing-a-complaint/index.html.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases, we never share your information unless you give us written permission:
  Marketing purposes
  Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone’s health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice
- Effective Date of this Notice: January 1, 2026
- CMMHC Privacy Officer: Brittany Liberty, 320-230-0614, bliberty@cmmhc.com

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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. COBRA (and the description of COBRA coverage contained in this notice) applies only to group health plan benefits and not to any other benefits offered by your employer.

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 , your spouse, and dependent children 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, join a spouse's group health plan, or to obtain coverage through a public health program (e.g., Medicare or Medicaid). From time to time, governmental programs may be available to you to help you pay monthly premiums or save on 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 unless the Plan sponsor has chosen to subsidize the cost of 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. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, then the divorce or legal separation may be considered a qualifying event for you even if your coverage was reduced or eliminated before the divorce or separation.

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 parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?
When the qualifying event is the end of employment, a reduction in hours of employment, or the death of the employee, the Plan will offer COBRA continuation coverage to qualified beneficiaries. You do not need to notify your employer of any of the events listed in the last sentence.

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 later of (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event. You must provide this notice to: Brittany Liberty, HR Generalist, 320-230-0614, bliberty@cmmhc.com.

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 and spouses (if the spouse is a qualified beneficiary) may elect COBRA continuation coverage on behalf of all of the qualified beneficiaries, 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. If the employer offers a health Flexible Spending Account, COBRA coverage under a health Flexible Spending Account can last only until the end of the year in which the qualifying event occurred.

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 a qualified beneficiary is determined by Social Security to be disabled and notifies the employer in a timely fashion, all of the qualified beneficiaries in your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability would have to have started at some time before the 61st day after the covered employee's termination of employment or reduction in hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above).

The disability extension is available only if you notify the employer in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's disability determination.
- the date of the covered employee's termination of employment or reduction of hours; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension. In providing this notice, you must use the Plan's designated form (you may obtain a copy of this form from the employer at no charge). **If these procedures are not followed or if the notice is not provided to the employer during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.**

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event while receiving COBRA continuation coverage because of the covered employee's termination of employment or reduction of hours (including COBRA coverage during a disability extension period as described above), the spouse and dependent children receiving COBRA continuation coverage 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; 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. This extension is not available under the Plan when a covered employee becomes entitled to Medicare after his or her termination of employment or reduction of hours.

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 individual health insurance carriers, Medicaid, Medicare, 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).

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
Brittany Liberty
411 3rd Street North
Waite Park, MN 56387
320-230-0614

Important Notice from Central MN Mental Health Center About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Central MN Mental Health Center 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. Central MN Mental Health Center has determined that the prescription drug coverage offered by the Medica Health Plan for the plan year 2026 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, the following options may apply:

- You may stay in the Medica Health Plan and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date without penalty either:
    - During the Medicare prescription drug annual enrollment period, or
    - If you lose Medica Health Plan creditable coverage.
- You may stay in the Medica Health Plan and also enroll in a Medicare prescription drug plan. The Medica Health Plan will be the primary payer for prescription drugs and Medicare Part D will become the secondary payer.
- You may decline coverage in the Medica Health Plan and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do not enroll in the Medica Health Plan, you are not able to receive coverage through the plan unless and until you are eligible to reenroll in the plan at the next open enrollment period or due to a status change under the cafeteria plan or special enrollment event.

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 Central MN Mental Health Center 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 Central MN Mental Health Center 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:	01/01/2026
Name/Entity of Sender:	Central MN Mental Health Center
Contact Position/Office:	Brittany Liberty / Human Resources
Address:	411 3rd Street North, Waite Park, MN 56387
Phone Number:	320-230-0614

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, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.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+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): 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: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

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

NEVADA – Medicaid

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

NEW HAMPSHIRE – Medicaid

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

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: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
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: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access 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/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2026, 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

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, and displays 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 person shall 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 1/31/2026)

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution – as well as your employee contribution to employment-based coverage – is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based 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 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023, and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023, and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact:

Name of Entity/Sender:	Central MN Mental Health Center
Contact--Position/Office:	Brittany Liberty / Human Resources
Address:	411 3rd Street North, Waite Park, MN 56387
Phone Number:	320-230-0614

The Marketplace can help you evaluate your coverage options, including your 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 your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name: Central MN Mental Health Center		4. Employer Identification Number (EIN) 41-08731422
5. Employer address: 411 3rd Street North		6. Employer phone number: (320) 230-0611
7. City: Waite Park	8. State: MN	9. ZIP code: 56387
10. Who can we contact about employee health coverage at this job? Brittany Liberty		
11. Phone number (if different from above) (320) 230-0614	12. Email address: bliberty@cmmhc.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☒ Some employees. Eligible employees are:
    Employees regularly scheduled to work at least 30 hours per week.
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:
    Spouses and children up to age 26. Other dependents may also be eligible for coverage. Please refer to Medica's Summary Plan Description for the full list of eligible dependents.
  - ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly