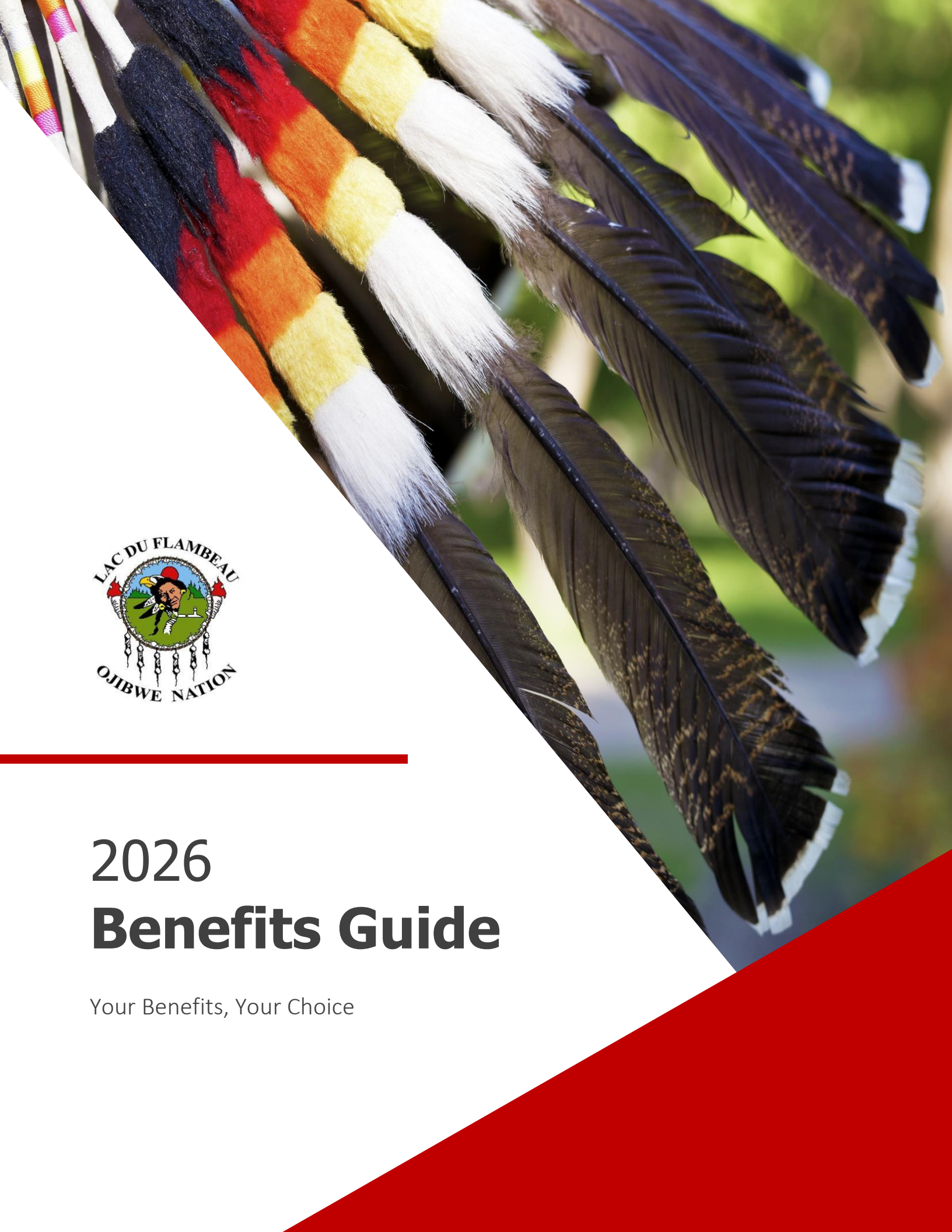


LAC DU FLAMBEAU
OJIBWE NATION

2026

Benefits Guide

Your Benefits, Your Choice

Highlights

- **Medical Insurance**
- **Health Savings Account**
- **Dental Insurance**
- **Vision Insurance**
- **Life/AD&D Insurance**
- **Disability Insurance**
- **Critical Illness Insurance**
- **Purchased/Referred Care (PRC)**
- **Wellness Program**
- **Annual Required Notices**

Important Resources:
Don't forget to check out LDF's benefit microsite for more information about employee benefits:
https://www.cbmicrosite.com/lacduflambeautribe

Disclaimer: The information described within this guide is only intended to be a summary of your benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description for a complete explanation of your benefits. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail. You can obtain a copy of the Summary Plan Description from the Human Resources Department.

Welcome!

At Lac Du Flambeau Band of Lake Superior Chippewa Indians (LDF) we are proud to offer our employees a wide variety of benefits to choose from, at the most affordable prices available.

We believe our commitment to your health and financial well-being is an important aspect of what we offer as an employer and we strive to provide enough choices that every individual and family can be appropriately covered through all stages of life.

Within this guide you will find the highlights of each benefit. When you choose to enroll in a benefit, the bi-weekly premium will be conveniently payroll deducted.

New Employees

Right now is your chance to elect the coverage you want for yourself and your family in 2026. We encourage you to read through this guide, share it with your family members, and ask us any questions that you may have so that you are educated and empowered to choose the benefits that are best for you.

Benefits will become effective on the 91st day of employment. If you don't take action now, you will not have the opportunity to enroll again until the next open enrollment period in November, unless you experience a qualifying life event as described on page 3.

Current Employees

Open enrollment takes place in November! This is your chance to make changes to your benefits and add or drop dependents. You will not get another chance to do this until the next open enrollment, unless you experience a qualifying life event.

Please make sure to enroll or make benefit changes before the deadline and come to us with any questions you have before that time. Thank you again for your service to Lac du Flambeau!

Benefit Contacts

Coverage/Service	Carrier	Phone Number	Website/Email
Medical Third Party Administrator	Auxiant	(800) 475-2232	www.auxiant.com
Dental Insurance	Delta Dental	(800) 236-3712	www.deltadentalwi.com
Basic Life, Long Term Disability, Whole Life, Accident, Critical Illness	Unum	(866) 679-3054	www.unum.com
Pharmacy Benefits Manager	IndigenousRx, *Powered by Liviniti*	(800) 710-9341	www.liviniti.com
FedLogic	FedLogic	(877) 837-4196	www.fedlogicgroup.com
Wellness Program	Lac du Flambeau in Partnership with **Integrated Health 21**	(715) 588-4225	cwatts@ldftribe.com
Lac du Flambeau Band of Lake Superior Chippewa Indians			
Carrie Watts	Health Benefits Coordinator	(715) 588-4225	cwatts@ldftribe.com

Eligibility, Enrollment & Changes

Eligibility

Employee

All full-time employees actively working 30 hours or more per week are eligible for Medical, Dental, and Vision benefits on the 91st day of employment. In addition, those working 32 hours or more per week are also eligible for disability, Voluntary Unum benefits and company paid life & AD&D. As a new employee, you have 30 days from your eligibility date to enroll in benefits.

- **Medical, Dental, Vision:** Medical, Dental, and Vision coverages will take effect on the date you are eligible.
- **Other Coverages:** All other coverages will take effect on the date you are eligible.

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

Dependents

- **Medical, Dental, Vision:** Employees enrolled in Medical, Dental, and Vision coverages also have the option to enroll their Dependent Spouse and Dependent Children on these plans. See below for a definition of an "eligible dependent" under these plans.
- **Other Coverages:** Employees enrolled in Voluntary Life/AD&D coverage also have the option to enroll their Dependent Spouse and Dependent Children. It is the responsibility of the employee to ensure dependents are eligible for coverage under these policies. Please refer to the policy certificate or HR for more information on dependent eligibility.

Definition of "Eligible Dependents"

The below definitions refer to Medical, Dental, and Vision Coverages.

- Your legal spouse who is a resident of the same country in which the Employee resides. Such spouse must have met all requirements of a valid marriage contract of the State in which the marriage of such parties was performed. For the purposes of this definition, "spouse" shall not mean a common law spouse or domestic partner.
- The employee's dependent children at the end of the month, in which, they attain age 26, legally adopted children from the date the employee assumes legal responsibility, foster children that live with the employee and for whom the employee is the primary source of financial support, children for whom the employee assumes legal guardianship and stepchildren.
- Also included are the employee's children (or children of the employee's spouse) for whom the employee has legal responsibility resulting from a valid court decree.
- Children who are mentally or physically disabled and totally dependent on the employee for support, past the age of 26 or older. To be eligible for continued coverage past the age of 26, certification of the disability is required within 31 days of attainment of age 26. A certification form is available from the employer or from the claims administrator and may be required periodically. You must notify the claims administrator and/or the employer if the dependent's marital or tax exemption status changes and they are no longer eligible for continued coverage.

Enrollment

How to Enroll

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

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

When to Enroll

Open enrollment begins on **11/1/2025 and runs through 11/30/2025.** The benefits you choose during open enrollment will become effective on 01/01/2026.

Changes

How to Make Changes

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

Qualifying life events include:

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

How My Medical Plan Works

LDF uses a PPO Network, which is all about choice. You get to choose which providers to visit each time you need care and you can help control your own medical costs by choosing providers from within the PPO. When you go out-of-network, you can visit any doctor or hospital you want, but you pay a greater portion of the cost.

In-Network Benefits:

- When you visit a provider that is within the PPO network, you will maximize the benefits of your medical plan. You do not have to select a Primary Care Physician, nor do you need a referral to see a specialist. Simply visit any doctor you choose within the PPO network for whatever care you need.
- Even within the PPO Network, you are responsible for the annual deductible before your plan begins paying coinsurance for most benefits. After your deductible is met, you are only responsible for your portion up to your annual out-of-pocket maximum.

Out-of-Network Benefits:

- Your plan allows you to visit any provider you want, even if they are not within the PPO network. However, you will pay more for the services of any provider who is out-of-network and you will have to satisfy your out-of-network deductible before the plan's coinsurance kicks in.
- When you visit an out-of-network provider, the plan bases its payments on what it considers the usual & customary rate (U&C) for each service provided. If the charge incurred is more than the U&C limit set forth by the plan, you are responsible for paying the full difference between the charge and what the plan pays.
- When you receive out-of-network care, you are responsible for filing claim forms for reimbursement. As with in-network providers, you will still need to contact HealthCorp to pre-certify hospital stays and certain outpatient procedures

Pre-Certification/Utilization Review

HealthCorp

- (877) 457-6223
- **www.cb-sisco.com**

Terms to Know:

- **In-Network:** The doctors and hospitals that participate in the plan by accepting negotiated discounts to their fees.
- **Copay:** A flat dollar amount that you are required to pay at the time of service for Medical or Rx Drugs. Not all Health Plans use copays.
- **Out-of-Pocket Maximum:** The maximum amount that you could be responsible for paying in any plan year, including your deductible, copays, and coinsurance, before the health plan covers 100% of remaining eligible expenses.
- **Deductible:** Your initial portion of Healthcare costs that you will pay before your plan begins cost-sharing.
- **Coinsurance:** The percentage of the cost you will pay after you meet your deductible
- **Usual & Customary (U&C):** The most a plan will consider eligible for a covered expense. U&C charges are based on the range of fees charged by providers with comparable training for the same or similar services in your area. When you receive care in-network, U&C allowance limitations do not apply

Medical Insurance: High Deductible Health Plan

Auxiant

For a complete list of your in-network and out-of-network benefits, please refer to your Medical Insurance Summary Plan Description, provided by Human Resources.

Medical: High Deductible Health Plan (HDHP)	In-Network	Out-of-Network
Annual Deductible		
Individual	$2,000	$4,000
Family	$4,000	$8,000
Coinsurance (percent paid after you reach your annual deductible)		
Plan Pays	90%	60%
You Pay	10%	40%
Annual Out-of-Pocket Maximum		
Individual	$4,000	$6,350
Family	$6,000	$12,700
Covered Services		
Preventive Care	100%	Not Covered
Primary Care Office Visit	Deductible, then Coinsurance	Deductible, then Coinsurance
Specialist Office Visit	Deductible, then Coinsurance	Deductible, then Coinsurance
Urgent Care	Deductible, then Coinsurance	Deductible, then Coinsurance
Emergency Room	Deductible, then Coinsurance	Deductible, then In-Network Coinsurance (90% coverage)
Hospitalization	Deductible, then Coinsurance	Deductible, then Coinsurance
Prescription Drugs	**PCHC Pharmacy**	**All Other Participating Pharmacies: All Tier Levels**
Preventive	No Charge	20% Coinsurance (deductible waived)
Non-Preventive	No Charge AFTER Deductibles	20% Coinsurance AFTER Deductible

Employee Contributions	Per Pay Period
1 Person	$52.29
2 People	$104.80
3 People	$156.37
4 or More People	$173.63

Health Savings Account (HSA)

*Available to employees enrolled on **the High Deductible Health Plan (HDHP).***

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

If you are a Tribal Member accessing PRC dollars and/or seeking care at an IHS facility, please consult with your Tax Advisor on eligibility for pre-tax contributions into an HSA.

What Are the Benefits of an HSA?

There are many benefits of using an HSA, including the following:

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

HSA Contribution Limits

The maximum amount that you can contribute to an HSA is $4,400 (individual) or $8,750 (family) in 2026.
If you are age 55 or older, you may make an additional "catch-up" contribution of $1,000. You may change your contribution amount at any time throughout the year as long as you don't exceed the annual maximum.

HSA Case Study

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

Year 1	
HSA Balance	$1,000
Total Expenses: Prescription drugs: $150	(-$150)
HSA Rollover to Year 2	$850
Since Justin did not spend all of his HSA dollars, he did not need to pay any additional amounts out-of-pocket this year.	

→

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

Medical Insurance: Clinic/PPO Plan

Auxiant

For a complete list of your in-network and out-of-network benefits, please refer to your Medical Insurance Summary Plan Description, provided by Human Resources.

Medical: Clinic/PPO Plan	Peter Christensen Health Center (PCHC)	Outside of PCHC: The Alliance PPO Network	Out-of-Network
Annual Deductible			
Individual	None	$2,000	$4,000
Family	None	$4,000	$8,000
Coinsurance (percent paid after you reach your annual deductible)			
Plan Pays	N/A	90%	60%
You Pay	N/A	10%	40%
Annual Out-of-Pocket Maximum			
Individual	$4,000	$4,000	$6,350
Family	$6,000	$6,000	$12,700
Covered Services			
Preventive Care	100%	100%	Not Covered
Primary Care Office Visit	$10 Copay Per Visit	Deductible, then Coinsurance	Deductible, then Coinsurance
Specialist Office Visit	$10 Copay Per Visit	Deductible, then Coinsurance	Deductible, then Coinsurance
Urgent Care	$10 Copay Per Visit	Deductible, then Coinsurance	Deductible, then Coinsurance
Emergency Room	N/A	Deductible, then Coinsurance	Deductible, then In-Network Coinsurance (90% coverage)
Hospitalization	N/A	Deductible, then Coinsurance	Deductible, then Coinsurance
Prescription Drugs	**PCHC Pharmacy***	**Other Pharmacies**	**Out-of-Network**
Generic	$5 Copay Per Prescription	20% Coinsurance	***Note:** Mail Order is not available through Clinic (PCHC) pharmacy. **Out-of-Network Prescriptions:** 40% Coinsurance
Preferred Brand	$10 Copay Per Prescription	20% Coinsurance	
Non-Preferred Brand	$50 Copay Per Prescription	20% Coinsurance	
Specialty	*Use Above Referenced Copays*	*Use Above Referenced Copays*	

Employee Contributions	Per Pay Period
1 Person	$60.15
2 People	$119.70
3 People	$179.82
4 or More People	$199.68

Understanding The Medical Plan

In-Network vs Out-of-Network

The Basics

Knowing the difference between an in-network and out-of-network provider can save you a lot of money.

- **In-network Provider**—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.
- **Out-of-network Provider**—A provider who is not contracted with your health insurance company.

Getting the Most Out of Your Care

Calling the physician directly and double-checking with your insurance company is the best way to ensure that the provider is in-network.

If you are receiving surgery, make sure to ask if the service is completely in-network. Often times, things such as anesthesia are not covered even though the primary physician is in-network.

Billing & Claim Differences

Because in-network and out-of-network providers are treated differently by your health insurance company, you will be billed differently depending on the type of provider you use for your care.

In-network Bill

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

Out-of-network Bill

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

Preventive Care

Preventive care is a type of health care whose purpose is to shift the focus of health care from treating sickness to maintaining wellness and good health. This includes a variety of health care services, such as a physical examination, screenings, laboratory tests, counseling and immunizations.

Preventive care also helps lower the long-term cost of managing disease because it helps catch problems in the early stages when most diseases are more readily treatable. The cost of early treatment or diet or lifestyle changes is less than the cost of treating and managing a full-blown chronic disease or serious illness.

Dental Insurance

Delta Dental

LDF offers you the option to buy affordable Dental Insurance through **Delta Dental**. On this plan, you have the option to use any dentist; however, if you go out-of-network, the plan will reimburse based on the "Usual and Customary" fees. See Human Resources for a full summary description of benefits. As a reminder, LDF dependents are covered until age 19, unless they are a student, student dependents are covered until age 25.

To see if your provider is in-network, you can call (800) 236-3712 or visit www.deltadentalwi.com.

Dental	PCDC / Delta Dental Provider	Out-of-Network
Annual Deductible Individual / Family	$0 / $0	$0 per Member-Preventive $25 per Member-All Other Services
Annual Benefit Maximum	$1,200 Per Individual $6,000 Per Family	$1,000 Per Individual $2,000 Per Family
Diagnostic & Preventive Services Examinations, teeth cleaning (prophylaxis), fluoride treatments, space maintainers, bitewing & full-mouth X-rays, sealants. **Note:** Benefits Paid in this category of services do not apply to the Annual Maximum.	100%	80%
Basic Restorative Services Emergency treatment to relieve pain, fillings, simple extractions.	100%	80% After Deductible
Endodontic & Periodontal Services Root canal & gum disease treatment, oral surgery.	100%	80% After Deductible
Major Restorative Service Crowns, complete & partial dentures, implants, fixed bridges, repairs & adjustments.	100%	50% After Deductible
Orthodontia Services Per Employee, Spouse, Dependent Child to age 19; Students to age 25. **Note:** Benefits Paid apply to Annual Maximum.	100%	100%

Employee Contributions	Per Pay Period
Employee	$9.23
Family	$13.85

By utilizing a Delta PPO Provider, you can significantly reduce your out-of-pocket expenses, and make your Plan Maximums go farther. The table below is a typical example of this savings.

Savings Example	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Non-Network Dentist
Dentist's Normal Fee	$720	$720	$720
Allowed Amount	$590	$680	$680
Dentist fee adjustment due to Delta Agreement	$130	$40	$0
50% Benefit paid by plan	$295	$340	$340
Out-of-pocket cost for patient	$295	$340	$380

Vision Insurance

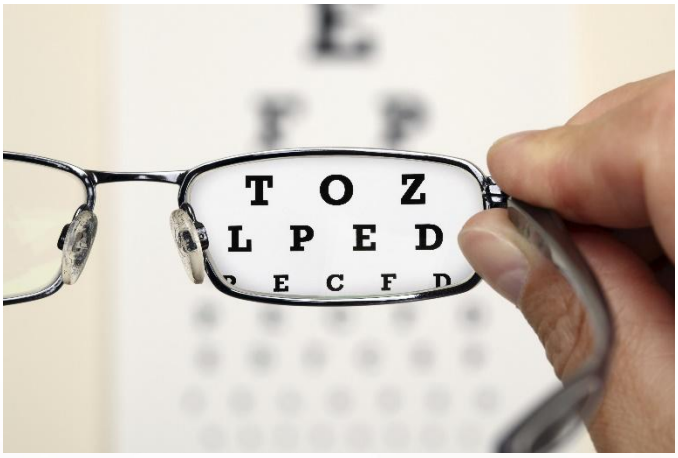
Peter Christensen Health Center

The vision plan is a voluntary employer-paid benefit and is provided at **Peter Christensen Health Center**. LDF dependents are covered until age 19 on the vision plan, unless they are a student, student dependents are covered until age 25.

If there are any questions regarding your Vision Plan please contact Employee Health Benefits at (715) 588-4225 or email at cwatts@ldftribe.com.

Vision	At Peter Christensen Health Center	Other Locations
Routine Vision Exam (One per Calendar Year)	100% Covered	60% up to $50 Maximum
Materials		
Lenses	100%	60%
Frames	100%	60%
Contacts	100%	60%
Maximum Per Person every 2 years		
Contact Lens Exam & Materials	$450	$100
Benefit Cost		
Lac du Flambeau Band of Lake Superior Chippewa Indians pays for the voluntary benefit.		

Note: Glasses and Contacts are covered once every 2 years. The vision benefit will reset on January 1, 2027.



Company-Paid Life/AD&D Insurance

Unum

Life insurance can help provide for your loved ones if something were to happen to you. The company provides all full-time, eligible employees with life and accidental death and dismemberment (AD&D) insurance.

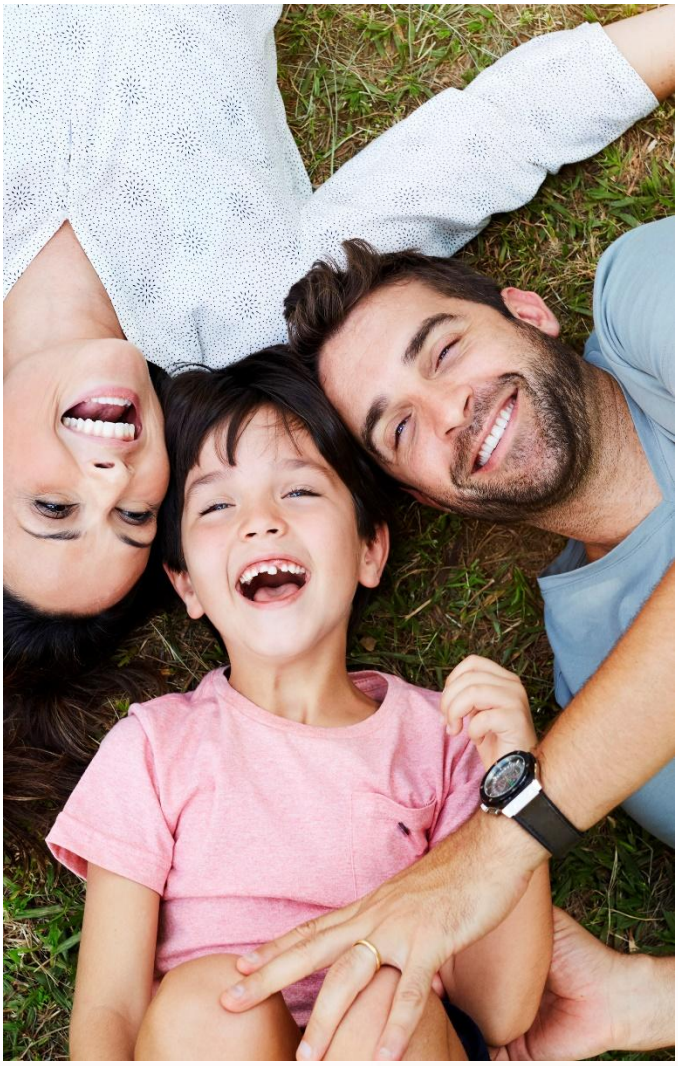
Beneficiaries

Your designated beneficiary will receive a benefit to help ease their financial burden if you die. If you do not update your beneficiaries, it will make it harder for the right person to receive your benefit, if ever needed. Please update your beneficiaries periodically!

Company-Paid Life/AD&D	
Life/AD&D Benefit Amount	**Class 1:** $200,000 **Class 2:** 2x Annual Earnings (up to $50,000 Max)
Reduction Schedule	**65% at age 70 and 50% at age 75**
Benefit Cost	100% paid by Lac du Flambeau

*AD&D pays a benefit for loss of life or dismemberment resulting from an accidental bodily injury. Your beneficiary will receive 100% of the AD&D amount if you die as the result of an accidental injury. You will receive an accidental dismemberment benefit if you lose a hand, a foot, or the sight of an eye due to an accidental injury. The benefit paid is 50% of the AD&D amount for any 1 loss and 100% of the AD&D amount for any 2 or more losses.

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



Voluntary Life/AD&D Insurance

Unum

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

With voluntary life insurance, you are responsible for paying the full cost of coverage through payroll deductions. You can purchase coverage for yourself or for your eligible dependent spouse and child(ren).

New Hire Notice

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

Voluntary Life/AD&D	
Life/AD&D Benefit Amount	**Employee:** $10,000 increments not to exceed 5 times Earnings or $500,000 **Spouse:** $5,000 increments to $500,000 not to exceed 100% of Employee Amount **Dependent Child(ren):** 0 days to 14 days – $1,000; 14 days to 6 months – $1,000; 6 months to age 19 – $5,000; Coverage to age 26 if a Full-Time student.
Guarantee Issue Amount**	**Employee:** $120,000 **Spouse:** $25,000 **If you enroll when first offered, you receive up to the listed amount without having to answer medical questions.
Reduction Schedule	65% at age 70 and 50% at age 75
Benefit Cost	Employee pays 100% of the premium. See Human Resources for list of rates.

Important – Please Read

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

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

Disability Insurance

Unum

The company provides eligible employees with company-paid short-term and long-term disability income benefits. Without disability coverage, you and your family may struggle to get by if you miss work due to an injury or illness.

In the event that you become disabled from a non-work-related injury or sickness, disability income benefits will provide a partial replacement of lost income. Please note, though, that you are not eligible to receive short-term disability benefits if you are receiving workers' compensation benefits.

Short-Term Disability	
Weekly Benefit Amount	60% of covered earnings to a maximum benefit of $1,500 per week
Elimination Period	30 Days
Benefit Duration	9 weeks
Employee Cost	100% paid by LDF

Long-Term Disability	
Monthly Benefit Amount	60% of covered earnings to a maximum benefit of $10,000 per month
Elimination Period	90 Days
Benefit Duration	To age 65
Pre-Existing Condition Limitations	This policy excludes pre-existing conditions for the first 12 months of your coverage. A pre-existing condition is defined as any condition for which you received medical treatment, consultation, care or services including diagnostic measures for the condition, or took prescribed drugs or medicines for it in the 3 months just prior to your effective date of coverage.
Employee Cost	100% paid by LDF

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

Whole Life Insurance

Unum

Lac Du Flambeau Band of Lake Superior Chippewa Indians (LDF) provides you the ability to purchase an affordable Whole Life Insurance through **Unum**.

The Whole Life insurance offers protection beyond an individual's working years, potentially for your lifetime. With a guaranteed death benefit that will never decrease, level premiums that will never increase, cash value accumulation, living benefits and other options, Whole Life goes beyond typical term life insurance.

Elections for this benefit can be made only during open enrollment.

Whole Life Insurance	
Family Coverage Options	Employee, Spouse and Child
Employee Coverage required for Spouse to have coverage	Yes
Spouse Benefit Amount up to the Employee Benefit Amount	Yes
Employee Coverage required for Child(ren) to have coverage	Yes
Purchase Option Type	Money Purchase
Purchase Option Type Child	Money Purchase
Paid Up Option*	Payable to Age 120 *Child always Paid Up to Age 70
Benefit Amounts**	Employee Options - $6, $9 Spouse Options - $3 Child Options – can be added to employee or spouse policy *All Policies issued are subject to minimum premium limits*
Employees (Money Purchase)	Health questions are not required for amounts up to $9 weekly premium.
Spouse (Money Purchase)	Health questions are not required for amounts up to $3 weekly premium.

Long-Term Care Rider

The Whole Life insurance policy comes with a Long-Term Care benefit rider. Long-Term Care can help cover the cost of medical and non-medical services that would otherwise be paid for out-of-pocket.

For more information about the cost associated with the Long-term Care Rider, please contact Human Resources.

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

Voluntary Accident Insurance

Unum

Lac Du Flambeau Band of Lake Superior Chippewa Indians (LDF) provides you the ability to purchase affordable Accident Insurance through **Unum**.

If you are accidentally injured, accident insurance can help you take care of out-of-pocket expenses and medical costs beyond what your existing health insurance plan covers.

Voluntary Accident	
Ground Ambulance and Air Ambulance	$400 / $1,500
Hospital Admission	$1,000
Intensive Care Unit Admission	$1,500
Confinement	$200 (per day up to 365 days per covered accident)
Intensive Care Unit Confinement	$400 (per day up to 15 days per covered accident)
Accidental Death, Dismemberment and Loss of Sight (AD&D)	
Loss of life	**Employee:** $50,000 **Spouse**: $20,000 **Child:** $10,000
Loss of both hands or both feet	$15,000
Loss of single hand or foot	$15,000
Multiple fingers and/or toes	$1,500
Single finger or toe	$750
Common carrier accidental death, dismemberment	**Employee:** $150,000 **Spouse:** $60,000 **Child:** $30,000
Fracture and Dislocation benefit	$75 to $7,500
Wellness Benefit	$50 per insured per calendar year

Elections for this benefit can be made only during open enrollment. For more information about the cost of the accident insurance, please contact Human Resources.

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

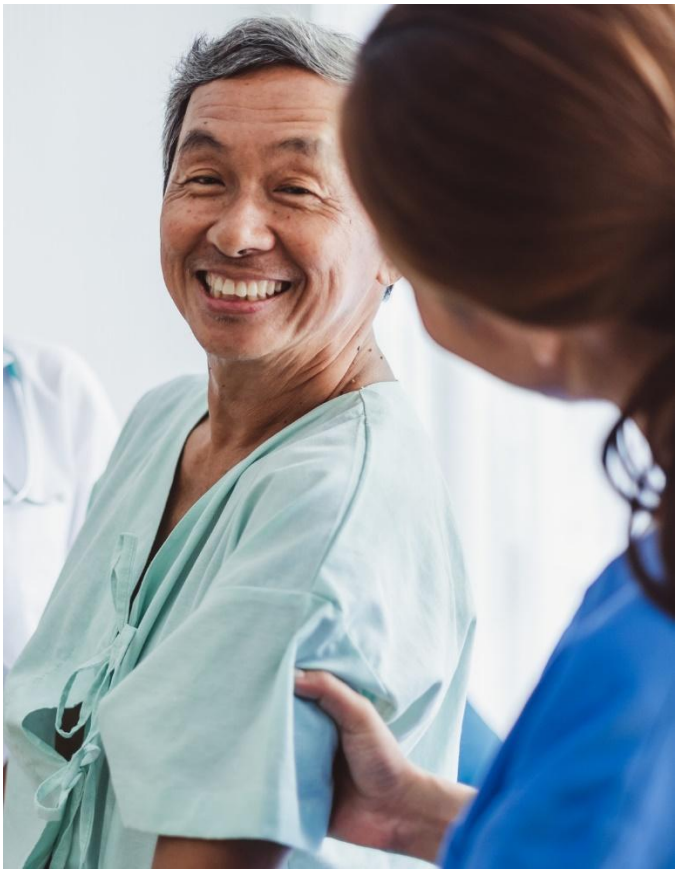
Critical Illness Insurance

Unum

Critical Illness insurance is designed to help employees offset the financial effects of a catastrophic illness with a lump sum benefit if an insured is diagnosed with a covered illness.

The Critical Illness benefit is based on the amount of coverage in effect on the date of diagnosis of a critical illness or the date treatment is received according to the terms and provisions of the policy.

Critical Illness with Cancer	
Covered Conditions	**For Critical Illness with Cancer:** Cancer, Carcinoma in Situ (25%), Heart Attack, Coronary Artery Bypass Surgery (25%), Stroke, End Stage Renal (Kidney) Failure, Major Organ Failure, Permanent Paralysis as the result of a Covered Accident, Coma as the result of Severe Traumatic Brain Injury, Blindness, Benign Brain Tumor, Occupational HIV. **Additional Covered Conditions for Dependent Children:** • Cerebral Palsy • Cleft Lip or Palate • Cystic Fibrosis • Down Syndrome • Spina Bifida
Family Coverage Options	Employee/Child, Spouse **Note:** Child coverage automatically included with Employee coverage.
Coverage Amount	**Employee Options:** $10,000, $20,000 **Spouse Options:** $10,000 **Child:** 25% of Employee Coverage Amount
Guaranteed Issue Limit Amount (health questions not required)	**Employee:** $20,000 **Spouse:** $10,000



Elections for this benefit can be made only during open enrollment. For more information about the cost of the Cancer coverage, please contact Human Resources.

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

PROTECT YOUR FINANCIAL WELLBEING WITH

Hospital Indemnity

Unum

It's no secret that a hospital stay can be extremely expensive, even with high-quality major medical insurance. A hospital indemnity insurance plan can help offset the costs incurred from a hospital stay.

What is hospital indemnity coverage?

Hospital indemnity coverage acts as a supplement to your health insurance and helps pay for certain medical-related expenses when you are hospitalized. For instance, your plan might help pay your deductible, copays or other typical out-of-pocket expenses. Like many other supplemental insurance plans, hospital indemnity insurance pays out a cash benefit directly to you.

What does hospital indemnity insurance cover?

Hospital indemnity insurance plans may cover inpatient hospital, intensive care unit (ICU) and critical care unit (CCU) admissions and stays. Some plans also cover outpatient surgery, ambulance transportation and continuous care expenses.

Benefits of Hospital Indemnity Coverage:

- You have the ability to customize your plan
- Keeps unexpected medical costs manageable
- Provides relief to parents who need to take time off to care for hospitalized child (if covered)

If you have any questions or want to learn more, please contact Human Resources.

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What is hospital indemnity coverage?

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Purchased/ Referred Care (PRC)

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

IHS Requirements

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

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

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

What Type of Care is Covered?

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

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

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

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

More Information

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

Federal Benefits Advocacy

FEDlogic | 877-837-4196 | www.fedlogicgroup.com

Your Very Own Personal Navigator

Lac du Flambeau Band of Lake Superior Chippewa Indians has partnered with FEDlogic to provide state and federal benefits information and advocacy to you and your household members. This service is confidential, unlimited, and free to all members and their families weather enrolled in benefits or not.

Below is a partial list of categories FEDLogic can assist with…

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

When You Need Us, It's All About You

We're passionate about providing highly personalized, easy, and practical phone consultation guidance to individuals and families. We never promote, endorse, or sell any type of product or insurance.

Contact

- 877-837-4196
- fedlogicgroup.com
- services@fedlogicgroup.com

Here's How it Works

Make a phone consultation appointment

① Call us at 877-837-4196 to schedule a phone consultation appointment with one of our federal and state benefits experts. Be sure to make the appointment at a time when family members are available to listen and ask questions. Calls typically last an hour.

Tell us your story, ask questions and learn

② You don't have to wade through tons of complex and confusing information to try to figure out what applies to you. We take the time to listen to your story and understand your needs, concerns, and goals. Then we empower you with the unbiased information you need so you can maximize your benefits and make the best decision for your situation.

Enroll for benefits

③ Once you feel confident you have the information you need to make the best decision for you and your family, we'll walk you through the application and approval process.

Relax and celebrate

④ Without education and advocacy, many people don't tap into all the Social Security and Medicare benefits they've paid into during a lifetime of employment. You'll have the peace of mind knowing that you're getting all the benefits you deserve. So, sit back, relax, and celebrate!

Information for Those Eligible for Medicare

What are my options once I turn 65?

If you continue to work full-time, you may remain on the company medical plan as long as you meet eligibility requirements. However, you may also be eligible for A & B, a Medicare Supplement and Medicare D. Please read the summary below and explore your options to determine what is best in your situation.

Working beyond age 65

If you are purchasing medical insurance through your employer, a Medicare plan could help you save money on your health care expenses. It may make sense for you to sign up for Medicare in addition to OR instead of the coverage you have today. If you enroll in Medicare and remain on the company health plan be sure to check the coordination rules to determine which coverage is primary.

Medicare Options:

Many people who choose to work past age 65 enroll in Part A (Hospital Insurance) because there is no monthly premium. You may choose to enroll in Medicare Part B, a Medicare Supplement, and/or Medicare Part D (these options will be subject to a monthly premium cost).

- Medicare Part B - Physician Insurance
- Medicare Part D – Drug Coverage.
- Supplemental Coverage – This can include Medigap coverages, employer plans or Medicaid.

It is recommended that you explore all options to determine what is best for you. You may also shop for and change plans each year based on your specific needs.

Understanding your options

Employees who choose to remain on the group health plan can sign up for premium-free Part A (if eligible) during or after their Initial Enrollment Period begins. You can only sign up for Part B (or Part A if you have to buy it) during certain enrollment periods as dictated by Medicare. For additional information on Medicare enrollment opportunities visit www.medicare.gov or reach out to your local SHIP office (see Medicare Resources for contact information).

Making changes to your Medicare plans:

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

Medicare Open Enrollment Period:

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

Retiring at or after age 65

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

Multiple Medicare resources available

Next Level Planning and Wealth Management

- Get advice from Licensed insurance agents at no cost or obligation to enroll
- Explore plans from numerous health insurance companies
- Learn more about Medicare and be guided through the process
- 1 on 1 assistance with benefit and financial planning
- Call (414) 369-6628 or visit www.NLPWM.com

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

Login using the following credentials:

USERNAME: Medicare

PASSWORD: Benefits65

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

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

Additional information (Government resources):

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

Benefit Terms

The world of health insurance has many terms that can be confusing. Understanding your costs and benefits—and estimating the price of a visit to the doctor—becomes much easier once you are able to make sense of the terminology.

Definitions

- **Annual limit**—Cap on the benefits your insurance company will pay in a given year while you are enrolled in a particular health insurance plan.
- **Claim**—A bill for medical services rendered.
- **Cost-sharing**—Health care provider charges for which a patient is responsible under the terms of a health plan. This includes deductibles, coinsurance and copayments.
- **Coinsurance**—Your share of the costs of a covered health care service calculated as a percentage of the allowed amount for the service.
- **Copayment (copay)**—A fixed amount you pay for a covered health care service, usually when you receive the service.
- **Deductible**—The amount you owe for health care services each year before the insurance company begins to pay. Example: John has a health plan with a $1,000 annual deductible. John falls off his roof and has to have three knee surgeries, the first of which is $800. Because John hasn't paid anything toward his deductible yet this year, and because the $800 surgery doesn't meet the deductible, John is responsible for 100 percent of his first surgery.
- **Dependent Coverage**—Coverage extended to the spouse and children of the primary insured member. Age restrictions on the coverage may apply.
- **Explanation of Benefits (EOB)**—A statement sent from the health insurance company to a member listing services that were billed by a provider, how those charges were processed and the total amount of patient responsibility for the claim.
- **Group Health Plan**—A health insurance plan that provides benefits for employees of a business.
- **In-network Provider**—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.
- **Inpatient Care**—Care rendered in a hospital when the duration of the hospital stay is at least 24 hours.
- **Insurer (carrier)**—The insurance company providing coverage.
- **Insured**—The person with the health insurance coverage. For group health insurance, your employer will typically be the policyholder and you will be the insured.
- **Open Enrollment Period**—Time period during which eligible persons may opt to sign up for coverage under a group health plan.
- **Out-of-network Provider**—A provider who is not contracted with your health insurance company.
- **Out-of-pocket Maximum (OOPM)**—The maximum amount you should have to pay for your health care during one year, excluding the monthly premium. After you reach the annual OOPM, your health insurance or plan begins to pay 100 percent of the allowed amount for covered health care services or items for the rest of the year.
- **Outpatient Care**—Care rendered at a medical facility that does not require overnight hospital admittance or a hospital stay lasting 24 hours or more.
- **Policyholder**—The individual or entity that has entered into a contractual relationship with the insurance carrier.
- **Premium**—Amount of money charged by an insurance company for coverage.
- **Preventive Care**—Medical checkups and tests, immunizations and counseling services used to prevent chronic illnesses from occurring.
- **Provider**—A clinic, hospital, doctor, laboratory, health care practitioner or pharmacy.
- **Qualifying Life Event**—A life event designated by the IRS that allows you to amend your current plan or enroll in new health insurance. Common life events include marriage, divorce, and having or adopting a child.
- **Qualified Medical Expense**—Expenses defined by the IRS as the costs attached to the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body.
- **Summary of Benefits and Coverage (SBC)**—An easy-to-read outline that lets you compare costs and coverage between health plans.

Acronyms

- **ACA**—Affordable Care Act
- **CDHC**—Consumer driven or consumer directed health care
- **CDHP**—Consumer driven health plan
- **CHIP**—The Children's Health Insurance Program. A program that provides health insurance to low-income children, and in some states, pregnant women who do not qualify for Medicaid but cannot afford to purchase private health insurance.
- **CPT Code**—Current procedural terminology code. A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities, such as physicians, health insurance companies and accreditation organizations.
- **FPL**—Federal poverty level. A measure of income level issued annually by the Department of Health and Human Services (HHS) and used to determine eligibility for certain programs and benefits.
- **FSA**—Flexible spending account. An employer-sponsored savings account for health care expenses.
- **HDHP**—High deductible health plan
- **HMO**—Health maintenance organization
- **HRA**—Health reimbursement arrangement. An employer-funded arrangement that reimburses employees for certain medical expenses.
- **HSA**—Health savings account. A tax-advantaged savings account that accompanies HDHPs.
- **OOP**—Out-of-pocket limit. The maximum amount you have to pay for covered services in a plan year.
- **PCE**—Pre-existing condition exclusion. A plan provision imposing an exclusion of benefits due to a pre-existing condition.
- **PPO**—Preferred provider organization. A type of health plan that contracts with medical providers (doctors and hospitals) to create a network of participating providers. You pay less when using providers in the plan's network, but can use providers outside the network for an additional cost.
- **QHP**—Qualified health plan. A certified health plan that provides an essential health benefits package. Offered by a licensed health insurer.

Lac du Flambeau Band of Lake Superior Chippewa Plan: Important Disclosures & Notices

Michelle's Law Notice

If the Plan provides for dependent coverage that is based on a dependent's full-time student status, then this Michelle's Law Notice applies. If there is a medically necessary leave of absence from a post-secondary educational institution or other change in enrollment that: (1) begins while a dependent child is suffering from a serious illness or injury; (2) is certified by a physician as being medically necessary; and (3) causes the dependent child to lose student status for purposes of coverage under the plan, that child may maintain dependent eligibility for up to one year. If the treating physician does not provide written documentation when requested by the Plan Administrator that the serious illness or injury has continued, making the leave of absence medically necessary, the plan will no longer provide continued coverage. ❖

Benefits during a Leave of Absence

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

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

If an Employee or an Employee's children are eligible for Medicaid or CHIP and are eligible for health coverage from an employer, the state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If the Employee or his/her children are not eligible for Medicaid or CHIP, they will not be eligible for these premium assistance programs but they may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If an Employee or his/her dependents are already enrolled in Medicaid or CHIP and they live in a State listed below, they may contact the State Medicaid or CHIP office to find out if premium assistance is available.

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

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

Employees living in one of the following States may be eligible for assistance paying employer health plan premiums. The following list of States is current as of July 31, 2025. V 0.6.0. The most recent CHIP notice can be found at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra. Contact the respective State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://dhss.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program
Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

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

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – Medicaid
Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

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

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

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website:
https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website:
https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine Relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine Relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website:
https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website:
https://dphhs.mt.gov/MontanaHealthcarePrograms/MemberServices
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

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

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

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program:
1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website:
http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

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

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website:
http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347 or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website:
https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website:
https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT – Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

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

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone:
1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/medicaid/index.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other States have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

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

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

Notice Regarding Wellness Program

The LDF Wellness Program powered by Integrated Health 21 is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions. You will also be asked to complete a biometric screening, which will include a blood test for glucose, triglycerides, HDL, LDL, etc. You are not required to complete the HRA or to participate in the blood test or other medical examinations. Although employees are not required to complete the HRA or participate in the

biometric screening, only employees who do so will receive the incentive.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You are also encouraged to share your results or concerns with your own doctor.

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Lac du Flambeau may use aggregate information it collects to design a program based on identified health risks in the workplace, The LDF Wellness Program powered by Integrated Health 21 will never disclose any of your personal information 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 individual(s) who will receive your personally identifiable health information is (are) a registered nurse, a doctor or a health coach in order to provide you with services under the wellness program. In addition, all medical information obtained through the wellness program will be maintained separate from your personal 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. ❖

Patient Protection Notice

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

Women's Health and Cancer Rights Act of 1998

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

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

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

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 or 96 hours, as applicable. Additionally, no group health plan or issuer may require that a provider obtain authorization from the Plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). ❖

Medical Child Support Orders

A Component Benefit Plan must recognize certain legal documents presented to the Plan Administrator by participants or their representatives. The Plan Administrator may be presented court orders which require child support, including health benefit coverage. The Plan Sponsor must recognize a Qualified Medical Child Support Order (QMCSO), within the meaning of ERISA section 609(a)(2)(B), under any Component Benefit Plan providing health benefit coverage.

A QMCSO is a state court or administrative agency order that requires an employer's medical plan to provide benefits to the child of an employee who is covered, or eligible for coverage, under the employer's plan. QMCSOs usually apply to a child who is born out of wedlock or whose parents are divorced. If a QMCSO applies, the employee must pay for the child's medical coverage and will be required to join the Plan if not already enrolled.

The Plan Administrator, when receiving a QMCSO, must promptly notify the employee and the child that the order has been received and what procedures will be used to determine if the order is "qualified." If the Plan Administrator determines the order is qualified and the employee must provide coverage for the child pursuant to the QMCSO, contributions for such coverage will be deducted from the employee's paycheck in an amount necessary to pay for such coverage. The affected employee will be notified once it is determined the order is qualified. Participants and beneficiaries can obtain a copy of the procedure governing QMCSO determinations from the Plan Administrator without charge. ❖

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information
When key parts of the health care law took effect in 2014, a new way to buy health insurance became available: the Health Insurance Marketplace. To assist Employees as they evaluate options for themselves and their family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by their employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help individuals and families find health insurance that meets their needs and fits their budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. Employees may also be eligible for a new kind of tax credit that lowers their monthly premium right away. The open enrollment period for health insurance coverage through the Marketplace began on Nov. 1st, and ended on Dec. 15. Individuals must have enrolled or changed plans prior to Dec. 15, for coverage starting as early as Jan. 1st. After Dec. 15th, individuals can get coverage through the Marketplace only if they qualify for a special enrollment period.

Can individuals Save Money on Health Insurance Premiums in the Marketplace?
Individuals may qualify to save money and lower monthly premiums, but only if their employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on premiums depends on household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If the Employee has an offer of health coverage from his/her employer that meets certain standards, they will not be eligible for a tax credit through the Marketplace and may wish to enroll in their employer's health plan. However, an individual may be eligible for a tax credit that lowers their monthly premium, or a reduction in certain cost-sharing if their employer does not offer coverage at all or does not offer coverage that meets certain standards. If the cost of a plan from an employer that would cover the Employee (and not any other members of their family) is more than 9.96% of household income for the plan year beginning in 2026, or if the coverage the employer provides does not meet the "minimum

value" standard set by the Affordable Care Act, the Employee may be eligible for a tax credit.*

Note: If a health plan is purchased through the Marketplace instead of accepting health coverage offered by an employer, then the Employee may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as the employee contribution to employer-offered coverage - is often excluded from income for Federal and State income tax purposes. Any Employee payments for coverage through the Marketplace are made on an after-tax basis.

How Can Individuals Get More Information?
For more information about coverage offered by the Employer, please check the summary plan description or contact Human Resources.

The Marketplace can help when evaluating coverage options, including eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in the area.

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs. ❖

Special Enrollment Rights

If an employee declines enrollment for him/herself or for their dependents (including their spouse) because of other health insurance coverage, they may be able to enroll him/herself or their dependents in this Plan in the future, provided they request enrollment within 30 days after their other coverage ends. Coverage will begin under this Plan no later than the first day of the first month beginning after the date the plan receives a timely request for enrollment.

If an employee acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption, they may be able to enroll him/herself and their dependents provided that they request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If an employee adds coverage under these circumstances, they may add coverage mid-year. For a new spouse or dependent acquired by marriage, coverage is effective no later than the first day of the first month beginning after the date the plan receives a timely request for the enrollment. When a new dependent is acquired through birth, adoption, or placement for adoption, coverage will become effective retroactive to the date of the birth, adoption, or placement for adoption. The plan does not permit mid-year additions of coverage except for newly eligible persons and special enrollees.

Individuals gaining or losing Medicaid or State Child Health Insurance Coverage (SCHIP)
If an employee or their dependent was:

1. covered under Medicaid or a state child health insurance program and that coverage terminated due to loss of eligibility, or
2. becomes eligible for premium assistance under Medicaid or state child health insurance program, a special enrollment period under this Plan will apply.

The employee must request coverage under this Plan within 60 days after the termination of such Medicaid or SCHIP, or within 60 days of becoming eligible for the premium assistance from Medicaid or the SCHIP. Coverage under the plan will become effective on the date of termination of eligibility for Medicaid/state child health insurance program, or the date of eligibility for premium assistance under Medicaid or SCHIP. ❖

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INDIVIDUAL MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW TO GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HIPAA Notice of Privacy Practices
The Lac du Flambeau Group Medical Plan (the "Plan"), which may include other health and welfare benefit offerings, are required by law (under the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 HIPAA's privacy rule) to take reasonable steps to ensure the privacy of personally identifiable health information. This Notice is being provided to inform employees (and any of their dependents) of the policies and procedures Lac du Flambeau has implemented and their rights under them, as well as under HIPAA. These policies are meant to prevent any unnecessary disclosure of individual health information.

Use and Disclosure of individually identifiable Health Information by the Plan that Does Not Require the Individual's Authorization: The plan may use or disclose health information (that is protected health information (PHI)), as defined by HIPAA's privacy rule) for:

1. Payment and Health Care Operations: In order to make coverage determinations and payment (including, but not limited to, billing, claims management, subrogation, and plan reimbursement). For example, the Plan may provide information regarding an individual's coverage or health care treatment to other health plans to coordinate payment of benefits. Health information may also be used or disclosed to carry out Plan operations, such as the administration of the Plan and to provide coverage and services to the Plan's participants. For example, the Plan may use health information to project future benefit costs, to determine premiums, conduct or arrange for case management or medical review, for internal grievances, for auditing purposes, business planning and management activities such as planning related analysis, or to contract for stop-loss coverage. Pursuant to the Genetic Information Non-Discrimination Act (GINA), the Plan does not use or disclose genetic information for underwriting purposes.

2. Disclosure to the Plan Sponsor:
As required, in order to administer benefits under the Plan. The Plan may also provide health information to the plan sponsor to allow the plan sponsor to solicit premium bids from health insurers, to modify the Plan, or to amend the Plan.

3. Requirements of Law:
When required to do so by any federal, state or local law.

4. Health Oversight Activities:
To a health oversight agency for activities such as audits, investigations, inspections, licensure, and other proceedings related to the oversight of the health plan.

5. Threats to Health or Safety:
As required by law, to public health authorities if the Plan, in good faith, believes the disclosure is necessary to prevent or lessen a serious or imminent threat to an individual's health or safety or to the health and safety of the public.

6. Judicial and Administrative Proceedings: In the course of any administrative or judicial proceeding in

response to an order from a court or administrative tribunal, in response to a subpoena, discovery request or other similar process. The Plan will make a good faith attempt to provide written notice to the individual to allow them to raise an objection.

7. Law Enforcement Purposes:
To a law enforcement official for certain enforcement purposes, including, but not limited to, the purpose of identifying or locating a suspect, fugitive, material witness or missing person.

8. Coroners, Medical Examiners, or Funeral Directors: For the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law.

9. Organ or Tissue Donation:
If the person is an organ or tissue donor, for purposes related to that donation.

10. Specified Government Functions:
For military, national security and intelligence activities, protective services, and correctional institutions and inmates.

11. Workers' Compensation:
As necessary to comply with workers' compensation or other similar programs.

12. Distribution of Health-Related Benefits and Services: To provide information to the individual on health-related benefits and services that may be of interest to them.

Notice in Case of Breach
Lac du Flambeau is required to maintain the privacy of PHI; to provide individuals with this notice of the Plan's legal duties and privacy practices with respect to PHI; and to notify individuals of any breach of their PHI.

Use and Disclosure of Individual Health Information by the Plan that Does Require Individual Authorization: Other than as listed above, the Plan will not use or disclose without your written authorization. You may revoke your authorization in writing at any time, and the Plan will no longer be able to use or disclose the health information. However, the Plan will not be able to take back any disclosures already made in accordance with the Authorization prior to its revocation. The following uses and disclosures will be made only with authorization from the individual: (i) most uses and disclosures of psychotherapy notes (if recorded by a covered entity); (ii) uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this notice.

Individual Rights with Respect to Personal Health Information: Each individual has the following rights under the Plan's policies and procedures, and as required by HIPAA's privacy rule:

Right to Request Restrictions on Uses and Disclosures: An individual may request the Plan to restrict uses and disclosures of their health information. The Plan will accommodate reasonable requests; however, it is not required to agree to the request, unless it is for services paid completely by the individual out of their own pocket. A wish to request a restriction must be sent in writing to HIPAA Privacy Officer, at Lac du Flambeau, PO Box 67, Lac du Flambeau, WI 54538, 715-588-4265.

Right to Inspect and Copy Individual Health Information: An individual may inspect and obtain a copy of their individual health information maintained by the Plan. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. A written request must be provided to HIPAA Privacy Officer at Lac du Flambeau, PO Box 67, Lac du Flambeau, WI 54538, 715-588-4265. If the individual requests a copy of their health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with their request.

Right to Amend Your Health Information: You may request the Plan to amend your health information if you feel that it is incorrect or incomplete. The Plan has 60 days after the request is made to make the amendment. A single 30-day extension is allowed if the Plan is unable to comply with this deadline. A written request must be provided to HIPAA Privacy Officer, at Lac du Flambeau, PO Box 67, Lac du Flambeau, WI 54538, 715-588-4265. The request may be denied in whole or part and if so, the Plan will provide a written explanation of the denial.

Right to an Accounting of Disclosures: An individual may request a list of disclosures made by the Plan of their health information during the six years prior to their request (or for a specified shorter period of time). However, the list will not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) disclosures made prior to April 14, 2004; (3) to individuals about their own health information; and (4) disclosures for which the individual provided a valid authorization.

A request for an accounting form must be used to make the request and can be obtained by contacting the HIPAA Privacy Officer at Lac du Flambeau, PO Box 67, Lac du Flambeau, WI 54538, 715-588-4265. The accounting will be provided within 60 days from the submission of the request form. An additional 30 days is allowed if this deadline cannot be met.

Right to Receive Confidential Communications: An individual may request that the Plan communicate with them about their health information in a certain way or at a certain location if they feel the disclosure could endanger them. The individual must provide the request in writing to the HIPAA Privacy Officer at Lac du Flambeau, PO Box 67, Lac du Flambeau, WI 54538, 715-588-4265. The Plan will attempt to honor all reasonable requests.

Right to a Paper Copy of this Notice: Individuals may request a paper copy of

this Notice at any time, even if they have agreed to receive this Notice electronically. They must contact their HIPAA Privacy Officer at Lac du Flambeau, PO Box 67, Lac du Flambeau, WI 54538, 715-588-4265 to make this request.

The Plan's Duties: The Plan is required by law to maintain the privacy of individual health information as related in this Notice and to provide this Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains.

Complaints and Contact Person:
If an individual wishes to exercise their rights under this Notice, communicate with the Plan about its privacy policies and procedures, or file a complaint with the Plan, they must contact the HIPAA Contact Person, at Lac du Flambeau, PO Box 67, Lac du Flambeau, WI 54538, 715-588-4265. They may also file a complaint with the Secretary of Health and Human Services if they believe their privacy rights have been violated. ❖

Important Notice from Lac du Flambeau Band of Lake Superior Chippewa Plan about Your Prescription Drug Coverage and Medicare (Creditable Coverage)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Lac du Flambeau 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. Lac du Flambeau has determined that the prescription drug coverage offered by the Lac du Flambeau Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current Lac du Flambeau coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Lac du Flambeau coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Lac du Flambeau 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 Lac du Flambeau changes. You also may request a copy of this notice at any time.

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: November 24, 2025
Name of Entity/Sender: Lac du Flambeau
Contact--Position/Office: Human Resources
Address: PO Box 67, Lac du Flambeau, WI 54538
Phone Number: 715-588-4265 ❖