2024-25 Benefits Guide






HARLAN MUNICIPAL UTILITIES
TELECOMMUNICATIONS
ELECTRIC GAS
WATER

HARLAN
a place to call HOME

CHIP NOTICE

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 company, 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 on the following page, 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, dial **1-877-KIDS NOW**, or visit **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 January 31, 2024. Contact your State for more information on eligibility.

To see if any other states have added a premium assistance program since January 31, 2024 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

State	Website/E-mail	Phone
Alabama (Medicaid)	**http://www.myalhipp.com/**	1-855-692-5447
Alaska (Medicaid)	*Premium Payment Program:* **http://myakhipp.com/** *Medicaid Eligibility:* **https://health.alaska.gov/dpa/Pages/default.aspx** *E-mail:* **CustomerService@MyAKHIPP.com**	1-866-251-4861
Arkansas (Medicaid)	**http://myarhipp.com/**	1-855-692-7447
California (Medicaid)	**http://dhcs.ca.gov/hipp** **hipp@dhcs.ca.gov**	916-445-8322 916-440-5676 (fax)
Colorado (Medicaid and CHIP)	*Medicaid:* **https://www.healthfirstcolorado.com/** *CHIP:* **https://hcpf.colorado.gov/child-health-plan-plus** *HIBI:* **https://www.mycohibi.com/**	1-800-221-3943 1-800-359-1991 1-855-692-6442 State relay 711
Florida (Medicaid)	**https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html**	1-877-357-3268

State	Website/E-mail	Phone
Georgia (Medicaid)	*HIPP:* **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp** *CHIPRA:* **https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra**	678-564-1162, press 1 678-564-1162, press 2
Indiana (Medicaid)	*Healthy Indiana Plan for low-income adults 19-64:* **http://www.in.gov/fssa/hip/** *All other Medicaid:* **https://www.in.gov/medicaid**	1-877-438-4479 1-800-457-4584
Iowa (Medicaid and CHIP)	*Medicaid:* **https://dhs.iowa.gov/ime/members** *CHIP:* **http://dhs.iowa.gov/Hawki** *HIPP:* **https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp**	1-800-338-8366 1-800-257-8563 1-888-346-9562
Kansas (Medicaid)	**https://www.kancare.ks.gov/**	1-800-967-4660 HIPP: 1-800-967-4660
Kentucky (Medicaid and CHIP)	*Medicaid:* **https://chfs.ky.gov/agencies/dms** *KI-HIPP:* **https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.apsx** *KI-HIPP E-mail:* **KIHIPP.PROGRAM@ky.gov** *KCHIP:* **https://kynect.ly.gov**	1-855-459-6328 1-877-524-4718
Louisiana (Medicaid)	**www.medicaid.la.gov** **www.ldh.la.gov/lahipp**	1-888-342-6207 1-855-618-5488
Maine (Medicaid)	**https://www.maine.gov/dhhs/ofi/applications-forms** **https://www.mymaineconnection.gov/benefits/s/?language=e n_US**	*Enroll:* 1-800-442-6003 *Private HIP:* 1-800-977-6740 TTY: Maine relay 711
Massachusetts (Medicaid and CHIP)	**https://www.mass.gov/masshealth/pa** **Email: masspremassistance@accenture.com**	1-800-862-4840 TTY: 711
Minnesota (Medicaid)	**https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp**	1-800-657-3739
Missouri (Medicaid)	**http://www.dss.mo.gov/mhd/participants/pages/hipp.htm**	573-751-2005
Montana (Medicaid)	**http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP** **HHSHIPPProgram@mt.gov**	1-800-694-3084
Nebraska (Medicaid)	**http://www.ACCESSNebraska.ne.gov**	1-855-632-7633 *Lincoln:* 402-473-7000 *Omaha:* 402-595-1178
Nevada (Medicaid)	**http://dhcfp.nv.gov/**	1-800-992-0900
New Hampshire (Medicaid)	**https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program**	603-271-5218 or 1-800-852-3345, ext. 5218
New Jersey (Medicaid and CHIP)	*Medicaid:* **http://www.state.nj.us/humanservices/dmahs/clients/medicaid/** *CHIP:* **http://www.njfamilycare.org/index.html**	*Medicaid:* 609-631-2392 *CHIP:* 1-800-701-0710
New York (Medicaid)	**https://www.health.ny.gov/health_care/medicaid/**	1-800-541-2831
North Carolina (Medicaid)	**https://medicaid.ncdhhs.gov/**	919-855-4100
North Dakota (Medicaid)	**https://www.hhs.nd.gov/healthcare**	1-844-854-4825
Oklahoma (Medicaid and CHIP)	**http://www.insureoklahoma.org**	1-888-365-3742
Oregon (Medicaid)	**http://healthcare.oregon.gov/Pages/index.aspx**	1-800-699-9075
Pennsylvania (Medicaid and CHIP)	Medicaid: **https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx** *CHIP:* **https://www.dhs.pa.gov/chip/pages/chip.aspx**	*Medicaid:* 1-800-692-7462 *CHIP:* 1-800-986-KIDS (5437)
Rhode Island (Medicaid and CHIP)	**http://www.eohhs.ri.gov/**	1-855-697-4347 or 401-462-0311 (Direct RIte)
South Carolina (Medicaid)	**https://www.scdhhs.gov**	1-888-549-0820
South Dakota (Medicaid)	**http://dss.sd.gov**	1-888-828-0059
Texas (Medicaid)	**https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program**	1-800-440-0493
Utah (Medicaid and CHIP)	*Medicaid:* **https://medicaid.utah.gov/** *CHIP:* **http://health.utah.gov/chip**	1-877-543-7669
Vermont (Medicaid)	**https://dvha.vermont.gov/members/medicaid/hipp-program**	1-800-250-8427
Virginia (Medicaid and CHIP)	**https://coverva.dmas.virginia.gov/learn/premiumassistance/famis-select** **https://coverva.dmas.virginia.gov/learn/premiumassistance/health-insurance-premium-payment-hipp-programs**	1-800-432-5924
Washington (Medicaid)	**https://www.hca.wa.gov/**	1-800-562-3022
West Virginia (Medicaid)	**https://dhhr.wv.gov/bms/** **http://mywvhipp.com/**	*Medicaid:* 304-558-1700 *CHIP:* 1-855-699-8447
Wisconsin (Medicaid and CHIP)	**https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm**	1-800-362-3002
Wyoming (Medicaid)	**https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/**	1-800-251-1269

This guide highlights the main features of many of the benefit plans sponsored by City of Harlan and Harlan Municipal Utilities. Full details of these plans are contained in the legal documents governing the plans. If there is any discrepancy between the plan documents and the information described here, the plan documents will govern. In all cases, the plan documents are the exclusive source for determining rights and benefits under the plans. Participation in the plans does not constitute an employment contract. City of Harlan and Harlan Municipal Utilities reserve the right to modify, amend or terminate any benefit plan or practice described in this guide. Nothing in this guide guarantees that any new plan provisions will continue in effect for any period of time. This guide serves as a summary of material modifications as required by the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

BENEFITS OVERVIEW

Our Benefits Program Has You Covered

Most days, we all count on our simple routines to get us through. Getting the kids to school, beating the traffic to work, and finishing dinner in time to enjoy a favorite hobby. But sometimes things don't always go as planned. Like when your head cold turns into the flu and you have to be out of work. Or your son's football game ends with a broken leg. Or even when your spouse learns he or she needs an extensive root canal. That's when the City of Harlan and Harlan Municipal Utility's benefits are there to help you.

Below is an overview of our benefits program, which gives you the coverage you need for all types of things life brings your way. The City of Harlan and Harlan Municipal Utility benefit plans allow you to choose the options that work best for your own needs — and your pocketbook. The key to getting the most from our benefits program is to take an active role in understanding and using the plans so that you are getting the best value for the money you spend.

You are eligible to enroll in the benefit plans if you are a regular, full-time employee scheduled to work at least 30 hours per week. As a regular, full-time employee, you are eligible for benefits on the first day of the month following 30 days of continuous service.

DEPENDENT ELIGIBILITY

You may also cover your eligible dependents, including:

- Your legal spouse.
- Your eligible children up to age 26 for medical, dental and vision coverage.
- "Children" are defined as your natural children, stepchildren, legally-adopted children, and children for whom you are the court-appointed legal guardian.
- Physically or mentally disabled children of any age who are incapable of self-support. Proof of disability may be requested.

If your child becomes ineligible for coverage (i.e., turning age 26 under the medical plan), you must notify the Human Resources Department at City of Harlan: 712-755-5137 / HMU: 712-755-5182.

WHEN COVERAGE BEGINS

Initial Enrollment

When you first join the City of Harlan, you have 30 days to enroll yourself and your dependents for benefits. If you enroll on time, coverage begins the first of the month following 30 days of employment. If you do not enroll within 30 days of becoming eligible, you will automatically be enrolled in company-sponsored benefits, such as Basic Life and Accidental Death & Dismemberment (AD&D) Insurance, but you will have to wait until the next annual Open Enrollment to enroll for other benefits and make changes to coverage.

Annual Open Enrollment

During annual Open Enrollment, coverage elected during this time frame will take effect on July 1, 2024.

Making Changes to Coverage

Once you make your benefit elections, these choices remain in effect until the next annual Open Enrollment unless you have a qualified status change, or you or your eligible dependents become eligible for coverage through special enrollment rules.

Qualifying Event

If you have a qualified status change or you have another allowable event, you can make certain changes during the plan year. However, you must make your enrollment change within 31 days of the event by completing a Benefit Changes/Enrollment form and returning it to Human Resources. If you do not return your form within 31 days, you will have to wait until the next Open Enrollment to make new elections. Certain qualifying events do allow for 60 days to make the corresponding enrollment change.

- Qualified status changes include, but are not limited to:
- Change in number of eligible dependents due to birth, adoption, placement for adoption, or death
- Gain or loss of dependent status (i.e., your child reaches the age limit for eligibility)
- Change in legal marital status, including marriage, divorce, or death of a spouse
- Change in residence or workplace that changes your or your dependent's eligibility for coverage
- Change in employment status, such as starting or ending employment, for you, your spouse, or your children
- End of the maximum period for COBRA coverage
- Loss of other coverage

For a more complete list of qualified status changes, refer to the Summary Plan Description.

Special Enrollment Rules

If you choose not to enroll yourself or your dependents (including your spouse) because you have other coverage, you may be able to enroll yourself and your dependents at a later date if:

- You or your dependents lose Medicaid or Children's Health Insurance Program ("CHIP") coverage as a result of a loss of eligibility for such coverage, or
- If you or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.
- Birth or Adoption of a child

You must enroll within 60 days of the qualified events shown in the "Special Enrollment Rules" above.

If your dependent also had other health coverage and lost that coverage in the above situations, they may be added to your coverage. However, you will not be able to add yourself or your dependents to this coverage if the other coverage was terminated "for cause" (including failure to pay the required premiums on time).

In addition to the changes described previously, you may enroll yourself and your spouse (with or without the new dependent) in a City of Harlan/Harlan Municipal Utility health plan following marriage, as long as you request enrollment within 31 days of the event. You must be enrolled to cover your dependents. If you have a special enrollment event and want to enroll for health coverage, call Human Resources at City of Harlan: 712-755-5137 / HMU: 712-755-5182.

CHOOSING A MEDICAL PLAN

City of Harlan and Harlan Municipal Utility's medical options all provide coverage for the same types of expenses, such as doctor's office visits, preventive care, prescription drugs, and hospitalization. You choose the option that makes the most sense for you and your family based on your needs and what you want to pay for coverage.

When it comes to medical coverage, City of Harlan and Harlan Municipal Utilities offers you a POS plan through Wellmark.

All of the providers in the Wellmark network change frequently. To find out if your doctor participates in the network, go to www.Wellmark.com and search Find a provider.

MEDICAL PLAN COMPARISON

Plan Feature	In-Network	Out-of-Network (1)	Wellmark Base Plan
Network	Blue Choice POS		
Annual Deductible			
Individual	$400		$2,500
Family	$800		$5,000
Annual Out-of-Pocket Maximum			
Individual	$500		$5,500
Family	$1,000		$7,900
Coinsurance	5%	40%	30%
Preventive Care	Covered in full	Covered in full with a Blue Card Provider	Covered in Full
Primary Care Physician	Deductible, 5% Coinsurance	Deductible, 40% Coinsurance	In-Network: Deductible, 30% Coinsurance
Diagnostics, X-Ray, and Lab Services	Deductible, 5% Coinsurance	Deductible, 40% Coinsurance	In-Network: Deductible, 30% Coinsurance
Urgent Care	Deductible, 5% Coinsurance	Deductible, 40% Coinsurance	In-Network: Deductible, 30% Coinsurance
Emergency Room	Deductible, 5% Coinsurance	Deductible, 5% Coinsurance	In-Network: Deductible, 30% Coinsurance
Inpatient Hospital Care	Deductible, 5% Coinsurance	Deductible, 40% Coinsurance	In-Network: Deductible, 30% Coinsurance
Outpatient Surgery	Deductible, 5% Coinsurance	Deductible, 40% Coinsurance	In-Network: Deductible, 30% Coinsurance

(1) For out-of-network providers, the member may incur some charges above usual, customary and reasonable, which are the responsibility of the member and do not apply to the out-of-pocket maximum.

PRESCRIPTION DRUG COVERAGE

If you enroll in one of the City of Harlan and Harlan Municipal Utility medical plans, you will automatically receive prescription drug coverage. For the POS plans, prescriptions are provided through Blue Rx Complete. When you need prescriptions, you can purchase them through a local retail pharmacy or, for medications you take on an ongoing basis, through the mail order program.

Retail Prescription Program

The retail prescription program uses a network of participating pharmacies. To receive the highest level of benefits, you must use a participating pharmacy. Prescriptions you fill at non-participating pharmacies are generally not covered.

Mail Order Program

The mail order program offers a convenient and cost-effective way to fill prescriptions for medications you take on a regular basis (maintenance medications). When you use the mail order program, you receive a 3-month supply of medication. Your medications are mailed directly to your home. To order prescriptions through the mail order program, you must fill out a mail order form and return it with a 90-day prescription from your doctor and your payment. Mail order forms are available from your HR Department or on the Wellmark website at www.MyWellmark.com.

Specialty Prescription Program

If you have a chronic condition and take specialty medications, you must purchase these through a designated specialty pharmacy that provides the best available pricing and additional support. If you have a prescription that meets this requirement, Wellmark will contact you and provide you with the necessary information to fill your prescription.

Prescription Drug Plan Highlights

Plan Feature	In-Network	Out-of-Network (1)	Wellmark Base Plan
Retail Prescriptions (up to 31-day supply)			
Tier 1	Deductible, 0% Coinsurance		In-Network: Deductible, 30% Coinsurance
Tier 2	Deductible, 20% Coinsurance		In-Network: Deductible, 30% Coinsurance
Tier 3	Deductible, 20% Coinsurance		In-Network: Deductible, 30% Coinsurance
Specialty	Deductible, 20% Coinsurance	Not Covered	In-Network: Deductible, 30% Coinsurance

Dental Plan Highlights

City of Harlan and Harlan Municipal Utility's Dental Plan is administered through Employee Benefit System and provides you and your family with coverage for typical dental expenses, such as cleanings, X-rays, fillings, and orthodontia for children.

Plan Feature	Amount You Pay
Annual Deductible **Individual** **Family**	 $25 $50
Annual Benefit Maximum	$1,000
Preventive Services **(Exams, routine cleanings, fluoride treatments)**	$25 Individual/$50 Family Deductible, 20% Coinsurance
Basic Services **(X-rays, fillings, sealants, denture repairs)**	$25 Individual/$50 Family Deductible, 20% Coinsurance
Major Services **(Crowns, inlays, onlays, bridges, dentures, implants)** **Waiting period for bridges, dentures & partial dentures—12 months***	$25 Individual/$50 Family Deductible, 50% Coinsurance
Orthodontia (dependent children to age 19)	$1,000 per lifetime for Orthodontia

You will not need a dental ID card to receive dental services. When you visit the dentist, give the provider your Social Security number and City of Harlan or Harlan Municipal Utility's name. Your dentist's office can verify your eligibility for benefits by calling EBS at 319-752-3200.

VISION PLAN

City of Harlan and Harlan Municipal Utility's Vision Plan promotes preventive care through regular eye exams and provides coverage for corrective materials, such as glasses and contact lenses. The Vision Plan is administered through Delta Vision.

Vision Coverage

If you enroll in vision coverage, you can go to any eye care provider you choose for care. However, if you choose providers who are part of the EyeMed Insight network, you will receive a discount on services. To find a network provider, go to www.deltadentalia.com.

The Vision Plan is designed to cover eye care needs that are visually necessary. You have to pay extra if you choose certain cosmetic or elective eyewear, so be sure to ask your eye doctor what items are covered by the plan before you purchase materials.

You will not need a vision ID card to receive vision services. When you visit the optometrist, give the provider your Social Security number and City of Harlan or Harlan Municipal Utility's name. Your optometrist's office can verify your eligibility for benefits by calling Delta Vision at 800-544-0717.

Vision Plan Highlights

	In-Network	Out-of-Network
Plan Feature	You Pay	Reimbursement
Exam	$10 Copayment	Up to $35
Prescription Glasses		
Single Lenses	$25 Copayment	Up to $25
Bifocals – Lined	$25 Copayment	Up to $40
Trifocals – Lined	$25 Copayment	Up to $55
Lenticular	$25 Copayment	Up to $55
Frames	80% of balance over $130	Up to $65
Contacts		
Medically Necessary	Paid in Full after Copay	Up to $200
Elective – In Lieu of Glasses	$130 Allowance	Up to $104
Lasik (per Lifetime)	85% of Retail price or 95% of Promotional price	
Benefit Frequency		
Exam	Once every calendar year	
Frames	Once every two calendar years	
Lenses or Contact Lenses	Once every calendar year	

LIFE INSURANCE

City of Harlan offers life insurance coverage to provide financial protection in the event you or your dependents die while you are still working. This coverage is administered through Reliance Standard.

Basic Life Insurance

City of Harlan and Harlan Municipal Utilities automatically provide Basic Life Insurance for all eligible employees at no cost. Basic Life Insurance is equal to 1.5 times your annual earnings, up to a maximum benefit of $200,000. The benefit is paid to your beneficiaries in the event of your death.

IRS Rules about Basic Life Coverage

If your Basic Life Insurance coverage is more than $50,000, your income taxes may be affected. IRS regulations require that the value of life insurance benefits over $50,000 be reported as “imputed income,” which is non-cash income that you receive from an employer-provided benefit. The value of any coverage that exceeds $50,000 will be reported to the IRS as imputed income on your W-2 form.

Voluntary Life Insurance

In addition to Basic Life Insurance, you may also purchase Voluntary Life Insurance for yourself, your spouse, and your dependent children. However, you may only elect coverage for your dependents if you enroll for Voluntary Life coverage for yourself.

Voluntary Life Insurance Coverage

Coverage For	Coverage Available
Employee	Increments of $5,000 to a maximum of $500,000 Guaranteed Issue for employees under 60 is $100,000
Spouse	Increments of $5,000 to a maximum of $500,000 Guaranteed Issue for spouses under 60 is $30,000
Child(ren)	Maximum Benefit of $1,000 if under 6 months Maximum Benefit of $10,000 if 6 months-20 Yrs., 26 Yrs. if full-time student

Beneficiary Designation

You must designate a beneficiary for Basic and Optional Life Insurance benefits when you enroll. Your "beneficiary" is the person(s) who will receive the benefits from your Life and AD&D coverage in the event of your death. You are always the beneficiary of any Dependent Life and AD&D Insurance you elect. You can change your beneficiaries at any time during the year.

If you do not name a beneficiary, or if your beneficiary dies before you, your Life and AD&D benefits will be paid to your estate.

Benefits Reductions

When you or a covered dependent reaches age 65, Basic Life Insurance benefits are reduced. When you or a covered dependent reaches age 75 and Optional Life Insurance benefits are reduced. For more information, refer to your Group Life Insurance booklet.

AD&D INSURANCE

City of Harlan and Harlan Municipal Utilities offer Accidental Death and Dismemberment (AD&D) Insurance for you and your family to help with expenses in the event you or a covered dependent dies or becomes injured as a result of an accident. This coverage is administered through Reliance Standard.

Basic AD&D Insurance

City of Harlan and Harlan Municipal Utilities automatically provide Basic AD&D Insurance for all eligible employees at no cost. Basic AD&D Insurance is equal to 1.5 times your annual earnings rounded to the next higher $1,000, up to a maximum benefit of $200,000. The total amount of your group life and AD&D coverage cannot exceed 1.5x times your annual base earnings.

Voluntary AD&D Insurance

In addition to Basic AD&D Insurance, you may also purchase Voluntary AD&D Insurance for you and your eligible dependents.

Beneficiary Designation

You must designate a beneficiary for Basic and Optional AD&D Insurance benefits when you enroll. Your "beneficiary" is the person(s) who will receive the benefits from your Life and AD&D coverage in the event of your death. You are always the beneficiary of any Dependent Life and AD&D Insurance you elect. You can change your beneficiaries at any time during the year. If you do not name a beneficiary, or if your beneficiary dies before you, your Life and AD&D benefits will be paid to your estate.

Voluntary AD&D Insurance Coverage

Coverage For	Coverage Available
Employee	Maximum Benefit of $500,000
Spouse	Maximum Benefit of $500,000
Child(ren)	Maximum Benefit of $1,000 if under 6 months Maximum Benefit of $10,000 if 6 months-20 yrs., 26 yrs. if full-time student

DISABILITY COVERAGE

City of Harlan and Harlan Municipal Utilities offer you two disability plans that work together to keep all or part of your paycheck coming if you cannot work because of illness, injury, or pregnancy. Short Term Disability benefits are administered through Employee Benefits System and Long Term Disability benefits are administered through Reliance Standard.

Short-Term Disability

Short-Term Disability (STD) benefits are provided by Employee Benefits System to all eligible employees at no cost. Your STD benefits will replace 60% of your weekly earnings for:

- 26 weeks to a maximum of $300 per week
- After you have used the greater of your available vacation, sick leave, and PTO or 7 days, then your STD benefits will begin if you are unable to work. The maximum benefit available is 26 weeks per STD claim.

Long-Term Disability

If you remain totally disabled and unable to work for more than 26 weeks, you may be eligible for Long-Term Disability (LTD) benefits. Reliance Standard automatically provides you LTD benefits that replace up to 60% of your monthly salary, up to a maximum of $6,000 per month. Your monthly LTD benefit will be reduced by Social Security and any other disability income you are eligible to receive (such as Workers' Compensation).

When Are You Disabled?

To be considered totally disabled and eligible for LTD benefits, you must be approved by the insurance carrier and seeing a doctor regularly for treatment. In addition:

- Your doctor must certify that you are not able to do your job at City of Harlan or Harlan Municipal Utilities, and

FLEXIBLE SPENDING ACCOUNTS

City of Harlan allows you to contribute to one or both Flexible Spending Accounts (FSAs), which allow you to save taxes on certain out-of-pocket health care and dependent care expenses. The FSAs are administered by Employee Benefits System.

How the FSAs Work

City of Harlan offers two types of FSAs:

- Health Care FSA
- Dependent Care FSA

If you elect to contribute to one or both of the FSAs, you choose an annual amount to be taken from each of your paychecks and deposited into your account throughout the year.

Your contributions are taken out of your paycheck before you pay taxes, so you save money. Then, when you have eligible health care or dependent care expenses, you can use the account to reimburse yourself, up to the amount you have elected to contribute to your account for the year.

With both accounts, the IRS requires you to use all of the money in your account by the end of the year or you lose it. This is called the "use it or lose it" rule with the exception of the carryover.

HEALTH CARE FSA

You can use the Health Care FSA to pay for eligible out-of-pocket expenses that are not covered by another health plan. Examples include, but are not limited to:

- Medical or dental deductibles
- Office visit copays
- Coinsurance amounts
- Amounts you pay for prescription drugs
- Amounts you pay for certain over-the-counter items
- Eyeglasses, contacts, and other vision-related expenses not covered by the vision plan
- Orthodontia expenses not covered by the dental plan

For a complete list of eligible expenses, visit www.fsastore.com.

Annual Contribution Amount

You can contribute up to $3,200 per year to the Health Care FSA.

Over-the-Counter Medications

You may use the Health Care FSA to reimburse yourself for over-the-counter medications. Examples of medications that you could purchase include:

- Acid controllers, digestive aids, and stomach remedies
- Allergy and sinus medicines
- Anti-itch and insect bite remedies
- Cold sore remedies
- Cold, cough, and flu drugs
- Pain relief medications
- Respiratory treatments
- Sleep aids and sedatives

Dependent Care FSA

The Dependent Care FSA helps you afford day care for your children under age 13 or for a disabled dependent. There are some special rules for participating in this account:

- The day care expenses must be necessary so you can work.
- You can only be reimbursed for expenses incurred during the plan year.
- If you are married, your spouse must be employed, a full-time student at least five months during the plan year, or mentally or physically disabled and unable to provide care for himself or herself.

In some cases, a federal child-tax credit may save you more money than the Dependent Care FSA. You may want to consult a tax advisor to find which option is better for you.

Eligible Dependent Care Expenses

Generally, you may use the money in your Dependent Care FSA for care for:

- Your children under age 13 whom you claim as a dependent for tax purposes.
- Other dependents of any age who are mentally or physically disabled and whom you claim as a dependent for tax purposes (spouses and dependents age 13 and older must spend at least eight hours a day in your home if you are reimbursing yourself for services provided outside the home).

Some typical expenses that are eligible for reimbursement under the plan are:

- Licensed nursery school and day care centers for children
- Licensed day care centers for disabled dependents
- Services from a care provider over the age of 19 (inside or outside the home)
- Day camps
- After-school care

Annual Contribution Amount

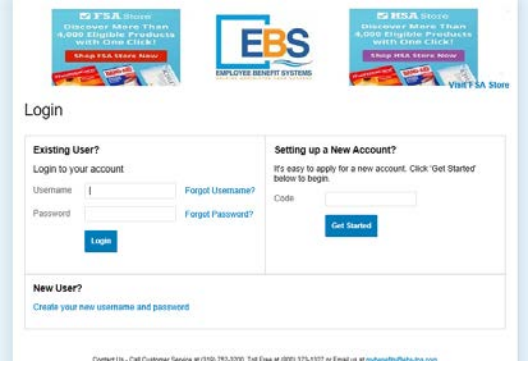
You can contribute up to $5,000 per year to the Dependent Care FSA if you are married filing jointly or head of household. If you are married and you and your spouse file separate tax returns, the maximum you can contribute is $2,500 each.

Important FSA Considerations

- Any money left in your FSAs at the end of the plan year may not be rolled over to pay for future expenses in another plan year. Any unused funds will be forfeited, per IRS rules.
- For the Dependent Care FSA, you may only be reimbursed up to the amount in your account at the time you file a claim. If your eligible expenses are greater than the amount in your account, the unreimbursed amount will carry over and be reimbursed after your next deposit. (For the Health Care FSA, you can be reimbursed up to the full amount you have elected to contribute for the year — even if you have not yet contributed that much to your account.)
- The Health Care FSA and the Dependent Care FSA are separate accounts. You cannot use funds from one account to pay for expenses of the other. You also cannot transfer funds between the two accounts.
- If you use the Dependent Care FSA, you must provide your caregiver's Social Security number or tax ID when you file a claim for reimbursement.

Set Up Direct Deposit
FSA, LFSA, DCA and HRA Reimbursements

Following are steps to login to your secure online portal the first time and to set up your direct deposit information. An account has been set up for you, so you are an **Existing User**. If you have already accessed your portal, and need a new password, call EBS at (800) 373-1327.



https://ebs-tpa.lh1ondemand.com

Username: first initial, last name, last 4 digits of SSN

Temporary Passcode: SSN# – no dashes or spaces

Change to your own password on first login

Set up some security questions

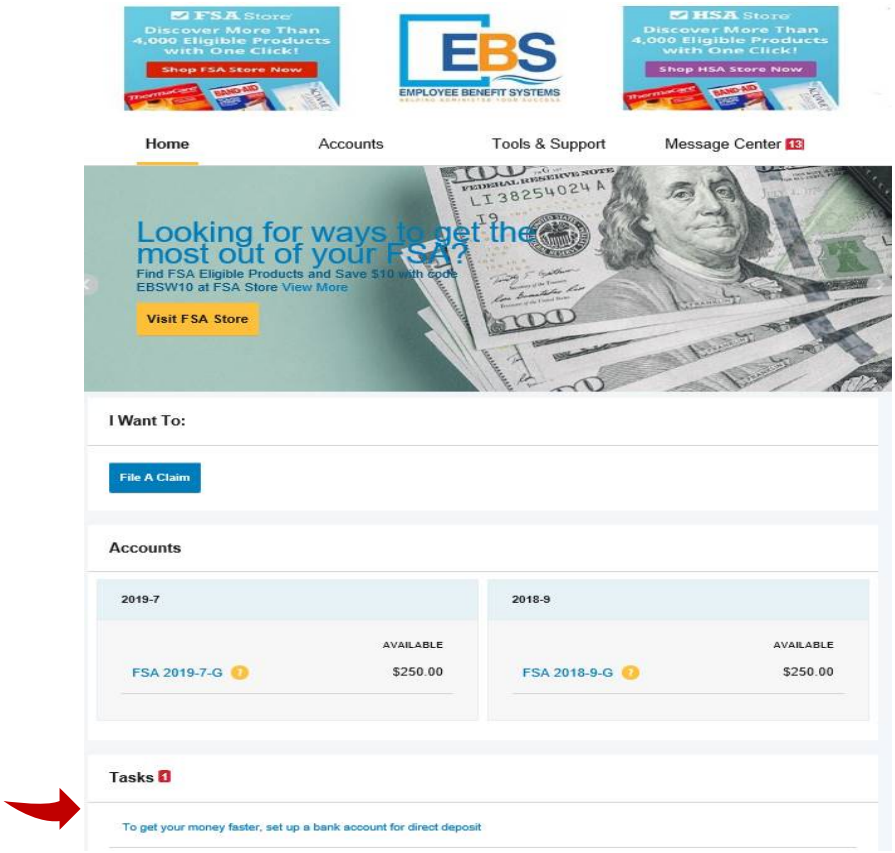
Welcome to your online portal

Scroll to the middle of the page under Tasks

Click on the link to set up your banking

To get your money faster, set up a bank account for direct deposit

Complete the Banking Information



Employee Benefit Systems - 214 North Main Street, Burlington, IA 52601
Phone: 800-373-1327 - Fax: 888-511-3743 - Email: mybenefits@ebs-tpa.com

Life comes with challenges.

Your Assistance Program is here to help.

Reach out to your Assistance Program for short-term counseling, financial coaching, caregiving referrals and a wide range of well-being benefits to reduce stress, improve mental health and make life easier.

The following services are free to use, confidential, and available to you and your family members:

Mental Health Sessions
Up to 3 telephonic sessions to help manage stress, anxiety and depression, resolve conflict, improve relationships, overcome substance abuse and address any personal issues.

Life Coaching
To help reach personal and professional goals, manage life transitions, overcome obstacles, strengthen relationships, and build balance.

Financial Consultation
To help build financial wellness related to budgeting, buying a home, paying off debt, managing taxes, preventing identify theft, and saving for retirement or tuition.

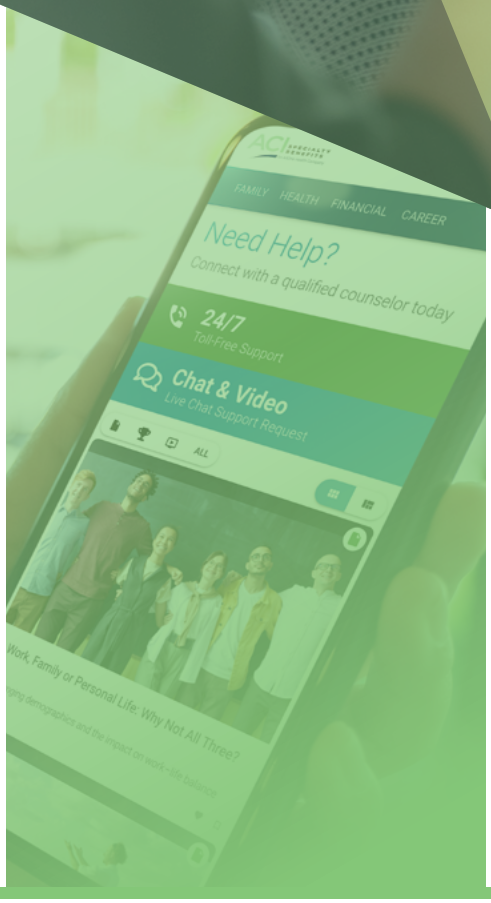
Legal Consultation
To help with a variety of personal legal matters including estate planning, wills, real estate, bankruptcy, divorce, custody, and more.

Life Management
To provide information and referrals when seeking childcare, adoption, special needs support, eldercare, housing, transportation, education, and pet care.

Personal Assistant
To help manage everyday tasks and give back time by providing information and referrals for home services, repairs, travel, entertainment, dining and personal services.

Medical Advocacy
To help navigate insurance, obtain doctor referrals, secure medical equipment or transportation, and plan for transitional care and discharge.

Member Portal and App
Access your benefits 24/7/365 with online requests and chat options, and explore thousands of articles, webinars, podcasts and tools covering total well-being.



EAP benefits are free of charge, 100% confidential, available to all family members regardless of location, and easily accessible through ACI's 24/7, live-answer, toll-free number.

EAP services are provided by ACI Specialty Benefits, under agreement with Reliance Standard Life Insurance Company.

Reliance Matrix is a branding name. Reliance Standard Life Insurance Company (Home Office Schaumburg, IL) is licensed in all states (except New York), the District of Columbia, Puerto Rico, the U.S. Virgin Islands and Guam. First Reliance Standard Life Insurance Company (Home Office New York, NY) is licensed in New York and Delaware. Standard Security Life Insurance Company of New York (Home Office New York, NY) is licensed in all states. Absence services are provided by Matrix Absence Management, Inc. Product features and availability may vary by state.

Contact ACI Specialty Benefits
855-775-4357
rsli@acieap.com
http://rsli.acieap.com
Company Code: RSLI859

reliancematrix
A MEMBER OF THE TOKIO MARINE GROUP

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ACI SPECIALTY BENEFITS
An AllOne Health Company

RS-2505 (10/22)

Introducing Your **Member Portal and App**

Browse benefits. Request services.
Enjoy 24/7/365 access.

Your Assistance Program offers a wide range of benefits to help improve mental health, reduce stress and make life easier—all easily accessible through your member portal and app.

Video, Chat and Telephonic Access

24/7/365 access to request mental health sessions and life management referrals

Thousands of Self-Care Articles and Resources

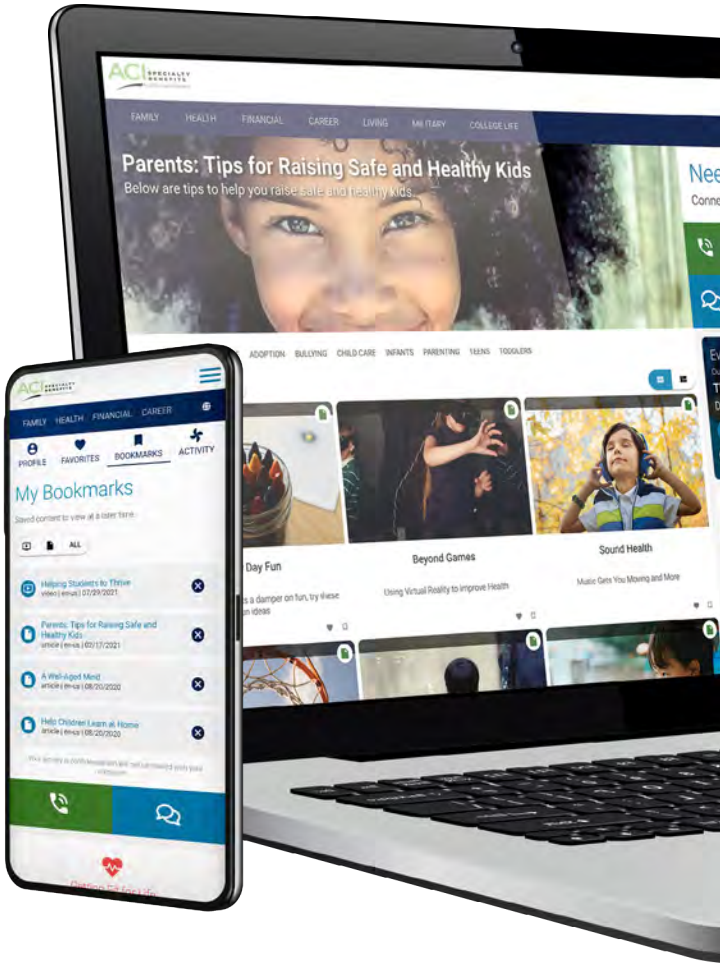
Explore videos, provider resource locators, personal assessments, calculators and tools

Events Calendar and Free Webinars

Sign up for the latest webinars and online training sessions

Exclusive Discounts

Save money on entertainment, gifts, travel and consumer goods



Getting Started Is Easy

1. Visit your landing page, **http://rsli.acieap.com**, and click on "Member Portal & App" in the top menu
2. Register to create a new account using your company code: **RSLI859**
3. A confirmation email will be sent to complete the process

EAP services are provided by ACI Specialty Benefits, under agreement with Reliance Matrix.

Reliance Matrix is a branding name. Reliance Standard Life Insurance Company (Home Office Schaumburg, IL) is licensed in all states (except New York), the District of Columbia, Puerto Rico, the U.S. Virgin Islands and Guam. First Reliance Standard Life Insurance Company (Home Office New York, NY) is licensed in New York and Delaware. Standard Security Life Insurance Company of New York (Home Office New York, NY) is licensed in all states. Absence services are provided by Matrix Absence Management, Inc. Product features and availability may vary by state.

Contact ACI Specialty Benefits
855-RSL-HELP (855-775-4357)
rsli@acieap.com
http://rsli.acieap.com
Company Code: RSLI859

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ACI SPECIALTY BENEFITS
An AllOne Health Company

IMPORTANT CONTACTS

Resource	Phone Number	Website/E-mail
Medical and Prescription	Wellmark: 800-591-3873 Employee Benefit Systems: 800-373-1327	www.wellmark.com www.ebs-tpa.com
Dental	Employee Benefits Systems: 800-373-1327	www.ebs-tpa.com
Vision	Delta Vision: 800-544-0718	www.deltadentalia.com
Flexible Spending Accounts	Employee Benefit Systems: 800-373-1327	www.ebs-tpa.com
Life/AD&D/Long Term Disability	Reliance Standard Life Insurance: 888-857-4801	www.reliancestandard.com
Short Term Disability	Employee Benefit Systems: 800-373-1327	www.ebs-tpa.com
EAP	Reliance Standard: 855-775-4357	Website: http://rsli.acieap.com Email: rsli@acieap.com

Wellmark Health Plan of Iowa

Coverage Period: 07/01/2024 – 06/30/2025
Coverage for: Single & Family | Plan Type: POS HDHP

IGHCP Plan 2 POS

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.wellmark.com or call 1-800-591-3873. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-591-3873 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,500** person/**$5,000** family per calendar year.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Well-child care and preventive care from in-network providers are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No. There are no other deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$5,500** person/**$7,900** family per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.wellmark.com or call 1-800-591-3873 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% coinsurance	40% coinsurance	For this plan you must select a Designated Primary Care Provider. PCP provider types can be found in the What You Pay section of your plan document.
	Specialist visit	30% coinsurance	40% coinsurance	Applies to Non-PCP providers. Hearing exams are covered according to ACA guidelines.
	Preventive care/screening/ immunization	No charge	40% coinsurance	One preventive exam and one mammogram per calendar year. Well-child care is covered to age 7. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	40% coinsurance	------None------
	Imaging (CT/PET scans, MRIs)	30% coinsurance	40% coinsurance	------None------

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-591-3873. You can find your Coverage Manual at sbccmfinder.wellmark.com.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.wellmark.com/prescriptions.	Tier 1	30% coinsurance	30% coinsurance	Drugs listed on Wellmark's Blue Rx Complete Drug List are covered. Drugs not on this Drug List are not covered. You pay the discounted cost of your prescription drugs until your overall deductible is met. For out-of-network prescription drugs, you may be balance billed. 30-day supply for prescription drugs. 90 day prescription maximum (maintenance). Specialty drugs are covered only when obtained through the CVS Specialty Pharmacy Program. Your plan includes coverage for certain specialty drugs through PrudentRx. If you choose to opt into the PrudentRx program, your coinsurance will be waived for drugs listed on the PrudentRx drug list. Information about the PrudentRx program can be found in your plan document in these sections: What You Pay, Details-Covered and Not Covered, Choosing a Provider, Factors Affecting What You Pay, and the Glossary. See wellmark.com/prescriptions for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your plan.
	Tier 2	30% coinsurance	30% coinsurance	
	Tier 3	30% coinsurance	30% coinsurance	
	Tier 4	30% coinsurance	30% coinsurance	
	Specialty drugs	30% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	40% coinsurance	------None------
	Physician/surgeon fees	30% coinsurance	40% coinsurance	------None------
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	For emergency medical conditions treated out-of-network, it is likely you may not be balance billed pursuant to the federal rules developed for implementation of the No Surprises Act.
	Emergency medical transportation	30% coinsurance	30% coinsurance	For covered non-emergent situations, out-of-network ground ambulance services are NOT reimbursed at the in-network level. The member may be balance billed for any out-of-network service as established under the rules developed for implementation of the No Surprises Act.
	Urgent care	30% coinsurance	40% coinsurance	------None------

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-591-3873. You can find your Coverage Manual at sbccmfinder.wellmark.com.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	40% coinsurance	------None------
	Physician/surgeon fees	30% coinsurance	40% coinsurance	------None------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	40% coinsurance	------None------
	Inpatient services	30% coinsurance	40% coinsurance	------None------
If you are pregnant	Office visits	30% coinsurance	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	30% coinsurance	40% coinsurance	Benefits shown reflect OB/GYN practitioner services which are typically globally billed at time of delivery for pre-natal, post-natal and delivery services.
	Childbirth/delivery facility services	30% coinsurance	40% coinsurance	------None------
If you need help recovering or have other special health needs	Home health care	30% coinsurance	40% coinsurance	------None------
	Rehabilitation services	30% coinsurance	40% coinsurance	------None------
	Habilitation services	30% coinsurance	40% coinsurance	------None------
	Skilled nursing care	30% coinsurance	40% coinsurance	------None------
	Durable medical equipment	30% coinsurance	40% coinsurance	20% coinsurance applies to in-network prosthetic limbs.
	Hospice services	30% coinsurance	40% coinsurance	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	------None------
	Children's glasses	Not covered	Not covered	------None------
	Children's dental check-up	Not covered	Not covered	------None------

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-591-3873. You can find your Coverage Manual at sbccmfinder.wellmark.com.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Custodial care - in home or facility
- Dental care - Adult
- Dental check-up
- Extended home skilled nursing
- Eye exam
- Glasses
- Hearing aids
- Long-term care
- Routine eye care - Adult
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Applied Behavior Analysis therapy
- Bariatric surgery
- Chiropractic care
- Infertility treatment ($15,000 LTM)
- Most coverage provided outside the U.S.
- Private-duty nursing -

short term intermittent home skilled nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, you can contact: Wellmark at 1-800-591-3873 or the Iowa Insurance Division at 515-654-6600.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

This contains only a partial description of the benefits, limitations, exclusions and other provisions of the health care plan. It is not a contract or policy. It is a general overview only. It does not provide all the details of coverage, including benefits, exclusions, and policy limitations. In the event there are discrepancies between this document and the Coverage Manual, Certificate, or Policy, the terms and conditions of the Coverage Manual, Certificate, or Policy will govern.

About These Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,500
PCP coinsurance	30%
Hospital(facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$3,000
What isn't covered	
Limits or exclusions	**$60**
The total Peg would pay is	**$5,560**

Managing Joe's type 2 Diabetes
(a years of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,500
Specialist coinsurance	30%
Hospital(facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	**$20**
The total Joe would pay is	**$3,420**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,500
Specialist coinsurance	30%
Hospital(facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$90
What isn't covered	
Limits or exclusions	**$0**
The total Mia would pay is	**$2,590**

The amounts shown in the maternity claim example above are based on amounts using a single per person deductible. Some plans may actually apply a two-person or family deductible to maternity services for the mother and newborn baby.

The plan would be responsible for the other costs of these EXAMPLE covered services.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-373-1327. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-591-3873 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	The employer self-funds a portion of the deductible under the major medical plan. **In-network deductible:** **$400** person/ **$800** family **Out-of-network deductible:** **$400** person/ **$800** family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. See the primary SBC of the insured group health plan.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	The employer self-funds a portion of the out-of-pocket maximum under the major medical plan. **In-network out-of-pocket maximum**: **$500** person/ **$1,000** family **Out-of-network out-of-pocket maximum:** **$500** person/ **$1,000** family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See the SBC of your primary group health plan	Your insured plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies. This is a summary of your enhanced benefits after your primary plan processes the claim. Your **copayment** and **coinsurance** remains the same as the primary plan unless otherwise noted.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	5% coinsurance	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Specialist visit	5% coinsurance	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Preventive care/screening/ immunization	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
If you have a test	Diagnostic test (x-ray, blood work)	5% coinsurance	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Imaging (CT/PET scans, MRIs)	5% coinsurance	See the primary SBC of the insured group health plan.	
If you need drugs to treat your illness or condition	Tier 1	0% coinsurance	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Tier 2	20% coinsurance	See the primary SBC of the insured group health plan.	
	Tier 3	20% coinsurance	See the primary SBC of the insured group health plan.	
	Tier 4	20% coinsurance	See the primary SBC of the insured group health plan.	
	Specialty drugs	20% coinsurance	See the primary SBC of the insured group health plan.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	5% coinsurance	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Physician/surgeon fees	5% coinsurance	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
If you need immediate medical attention	Emergency room care	5% coinsurance	5% coinsurance	See the primary SBC of the insured group health plan.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	5% coinsurance	See the primary SBC of the insured group health plan.	
If you have a hospital stay	Facility fee (e.g., hospital room)	5% coinsurance	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	5% coinsurance	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	5% coinsurance	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Inpatient services	5% coinsurance	See the primary SBC of the insured group health plan.	
If you are pregnant	Office visits	5% coinsurance	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Childbirth/delivery professional services	5% coinsurance	See the primary SBC of the insured group health plan.	
	Childbirth/delivery facility services	5% coinsurance	See the primary SBC of the insured group health plan.	
If you need help recovering or have other special health needs	Home health care	5% coinsurance	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Rehabilitation services	5% coinsurance	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Habilitation services	5% coinsurance	See the primary SBC of the insured group health plan.	
	Skilled nursing care	5% coinsurance	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Durable medical equipment	20% coinsurance	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Hospice services	5% coinsurance	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
If your child needs dental or eye care	Children's eye exam	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Children's glasses	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Children's dental check-up	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)
See the primary insured group health plan

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
See the primary insured group health plan

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Employee Benefit Systems at 1-800-373-1327, or Iowa Insurance Division at 515-654-6600.

Does this plan provide Minimum Essential Coverage? **No**. However, this plan combined with your primary insurance plan does provide Minimum Essential Coverage. Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? **No**. However, this plan combined with your primary insurance plan does meet Minimum Value Standards. If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [319-752-3200].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [319-752-3200].]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 [319-752-3200].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [319-752-3200].]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	$400
■ PCP coinsurance	5%
■ Hospital (facility) coinsurance	5%
■ Other coinsurance	5%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$400
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$560**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	$400
■ Specialist coinsurance	5%
■ Hospital (facility) coinsurance	5%
■ Other coinsurance	5%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$400
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$520**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ The plan's overall deductible	$400
■ Specialist coinsurance	5%
■ Hospital (facility) coinsurance	5%
■ Other coinsurance	5%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$500**

The amounts shown in the maternity claim example above are based on amounts using a single per person deductible. Some plans may actually apply a two-person or family deductible to maternity services for the mother and newborn baby.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

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Getting sick is bad enough without having to get out of bed to see a doctor. With Doctor On Demand, you and your family members can connect face-to-face with a board-certified doctor on your schedule.

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- Fever
- Headache
- Pink eye
- Skin condition
- Other conditions such as mental health (if covered by your group health plan)[1]

[1] Mental health treatment cost share is subject to group plan coverage. Mental health coverage includes psychiatry services and medication management along with treatment for psychological conditions, emotional issues and chemical dependency. For more information, call Wellmark with the number on the back of your ID card.

QUESTIONS? CALL 800-997-6196.

Callers could experience longer wait times between 10 p.m. and 6 a.m. CST or may be directed to schedule an appointment in some instances.

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my

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Clicking **Notifications.**

Choosing your preferences and click **Agree & Save.**

Wellmark complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意 : 如果您说普通话 , 我们可免费为您提供语言协助服务。请拨打 800-524-9242 或 (听障专线 : 888-781-4262) 。

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

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THE BENEFITS OF MAIL SERVICE

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SAVE MONEY — A 90-day supply using mail service typically costs less than multiple copayments of the same quantity dispensed at a retail pharmacy. Check your benefits on myWellmark for details.

Registered pharmacists make sure your order is right, and check for potential drug allergies and interactions. They're also available by phone to answer any questions.

Enjoy the extra convenience of automatic refills.

Save extra time with ReadyFill at Mail™. This automatic prescription refill and renewal program is a no-cost service provided by CVS/caremark Mail Service Pharmacy. The work of ordering is done for you, so you don't have to spend time online, on the phone or filling out a form. Sign up for this at the same time when you register for mail service at caremark.com.

Ask for Generic Drugs and Save

An easy way to save money is to buy generic medications when available and appropriate. Although generic drugs have the same active ingredients as the brand-name, they typically cost much less.

Your order will be reviewed to see if a generic medication is available. Unless otherwise noted by your prescriber or state law, you will get the generic equivalent when available to help you save money.

With home delivery service from CVS/caremark, your medicine arrives safely at your door in plain packaging – at no extra cost to you. You will also be told when a shipment is on the way so you can make changes or cancel at any time.

So, what do you do next?

IT'S EASY TO START AND EASY TO SAVE. HERE ARE TWO WAYS TO GET YOUR PRESCRIPTIONS USING MAIL SERVICE:

ONLINE AT CAREMARK.COM

CALL US AT 866-611-5961

Gateway Claims Portal

The EBS ***Gateway Claims Portal*** provides a more efficient method to access your claims information electronically and provides you immediate access.

Easy Steps for on-line access:

1. **First time accessing the Gateway Claims Portal** - log on to the EBS website at www.ebs-tpa.com and click on **First time Gateway users click here for your registration code** (underneath the Gateway Claims login). Answer the security questions and you will receive your secure registration code via email within one business day.
2. Once you receive your secure registration code, click on the orange **Gateway Claims login** button in the upper right hand corner of the EBS website. *(Gateway supports up-to-date versions of the following browsers: Chrome, Internet Explorer 11, Microsoft Edge, Firefox, and Safari.)*
3. Select **Click here to register and /or enroll** – then select the drop down and choose **Member**.
4. Enter the required information including the registration code you received from EBS via email.
5. Create your own unique username and password and submit.
6. An email will be sent to you to activate your account. Once activated you can log in.

Technical Difficulties:

Already registered but forgot your username or password? If you have already registered for **Gateway** but you have forgotten your username or password please email **gatewaysupport@ebs-tpa.com** and we will assist you further.

What if my registration submission "Failed to Register" because "Member Information not Found"? Check that the formatting of the Date of Birth matches what is shown on the website. (Slashes instead of dashes and the full four numbers of the year)

What if I did not receive the registration confirmation email with the link? Check your junk email or spam folder.

Why aren't EOB's opening? Check to make sure your browser is allowing pop-ups for this website.

Why can't I see claims for all of my family members? Due to HIPAA regulations, family members over the age of 18 have the right to privacy in terms of their claims information. Contact Gateway Support for assistance.

Help, I'm still having technical difficulties. Email (gatewaysupport@ebs-tpa.com) or call (800-373-1327) and ask for Gateway Support.

Great news! Employee Benefit Systems (EBS) is partnering with Zelis Payments so you can quickly and easily receive reimbursements direct to your bank account using direct deposit. To enroll with Zelis Payments member direct deposit, please follow the registration instructions below.

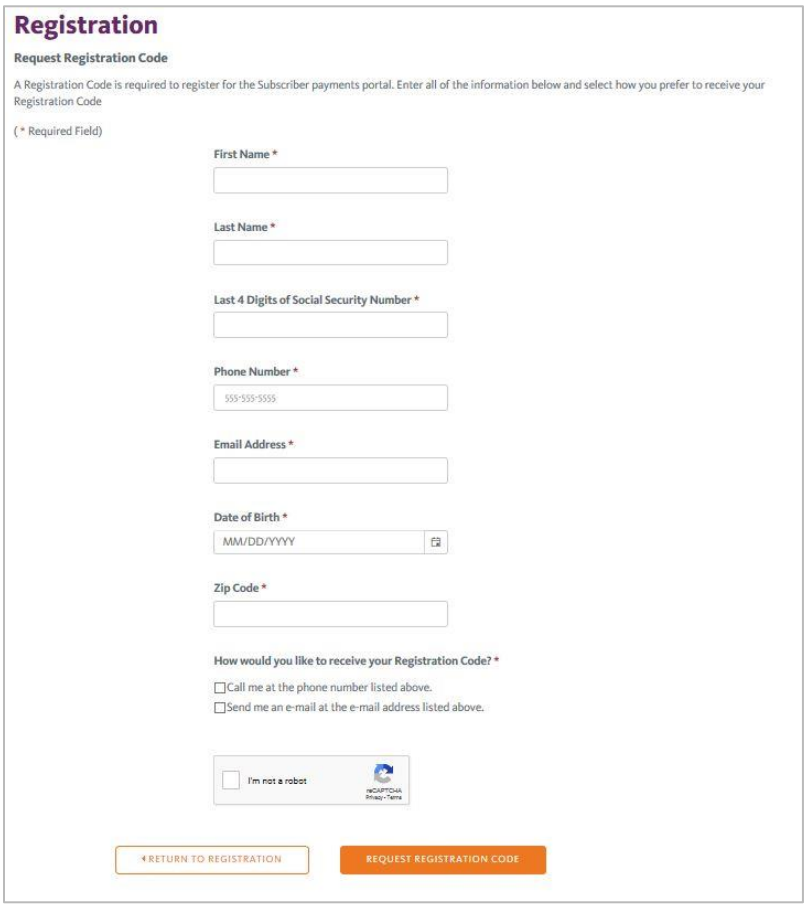
Why should I enroll in Zelis Payments direct deposit?

- **Receive payments faster** – no need to wait up to 10 days for a check in the mail. You'll get paid within 1-2 business days of receiving a payment notification.
- **No transaction fees** – all fees associated with direct deposit are covered courtesy of EBS.
- **Manage payment and banking records instantly –** gain immediate access online to view previous payments, explanation of payment (EOP), manage banking information and to set up customized notifications.

It is easy to enroll:

Enrolling is fast and easy! Visit **member.zelispayments.com** and click "Sign-Up Now!" to create an account. Follow the instructions below as a guide:

- **1 - Request your registration code:**



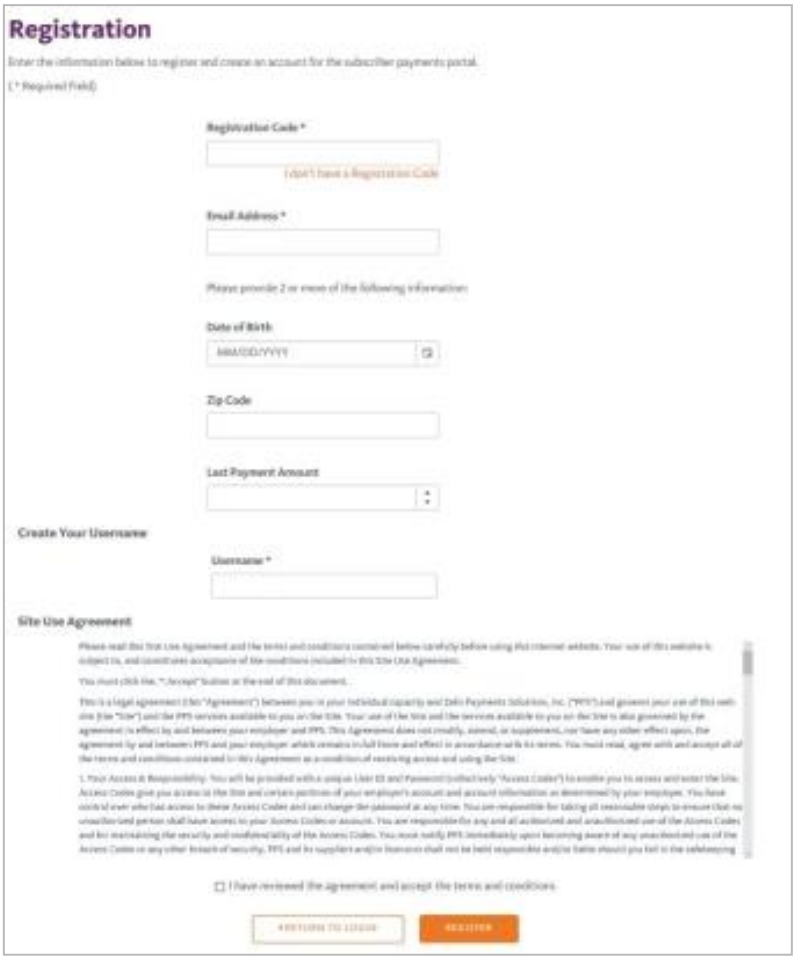
Click the "I don't have a Registration Code" link on the enrollment page.

Complete the required fields with your contact information and select how you would like to receive your code.

Click "Request Registration Code".

Once you have received a code via phone or email make sure to follow the rest of the instructions below.

- **2 - Enter your registration code:**



Enter your registration code and your email address.

Ensure that all other fields have been filled in, select your username and click “Register.”

- **3 - Create a password:**
  - Once you’ve clicked “Register” you will receive an automated email with a link to create your password.
  - After adding your password, you will be redirected to a log in screen. From here you can access your new account.
- **4 - After logging in, select Zelis ACH:**
  - Your user account is now active! Make sure to select Zelis ACH to complete adding direct deposit.
  - Once you’ve completed your bank setup, Zelis will initiate a pre-note test on the account provided for additional security verification. A small deposit will be made in a random amount no larger than $1.00.
  - Review your bank statement for the deposit and log-in to the Zelis portal to enter the exact amount for final confirmation.

Congrats! Now you can start receiving payments from EBS through direct deposit.

All payment information is available 24/7 via the Zelis Payments Member Portal and can be downloaded to PDF. For any additional information or questions please call the Zelis Payments Client Service department at 1-800-536-9042.

Employee Benefit Systems
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City of Harlan/Harlan Municipal Utilities

Contact Information

Phone: 1-319-752-3200
Phone Toll Free: 1-800-373-1327
Email: contactus@ebs-tpa.com

Administrators

Billing , Employee/Dependent Status Changes Administration
Emily Polson
Phone: 319-758-8445
Fax: 319-758-8545
Email: epolson@ebs-tpa.com

Flex Claims Administration
Tricia Zoarski
Phone: 800-373-1327
tzoarski@ebs-tpa.com

Dental Claims Administration
Vicky McCoy
Phone: 319-758-8476
Fax : 319-758-8576
vmccoy@ebs-tpa.com

Medical Claims Administration
Elaine Pence
Phone: 319-758-8456
Fax: 319-758-8556
epence@ebs-tpa.com

COBRA Administration
Kristi Reed
Phone: 319-758-8448
Fax : 319-758-8548
kreed@ebs-tpa.com

Additional Contacts

Benefit Specialist
Tabitha Langan
319-758-8483
tlangan@ebs-tpa.com

Director of Operations
Kelly Augustine
319-758-8457
kaugustine@ebs-tpa.com

Claims Manager
Jody Suminski
319-758-8452
jsuminski@ebs-tpa.com

Billing Manager
Jen Chezum
319-758-8474
jchezum@ebs-tpa.com

IMPORTANT NOTICE FROM CITY OF HARLAN/HMU 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 City of Harlan/HMU 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. City of Harlan/HMU has determined that the prescription drug coverage offered by all plans 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 City of Harlan/HMU coverage will [or will not] be affected.

If you do decide to join a Medicare drug plan and drop your current City of Harlan/HMU coverage, be aware that you and your dependents will not 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 City of Harlan/HMU 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 November to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…
Contact the person listed below for further. 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 City of Harlan/HMU 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:	07/01/2024
Name of Entity/Sender:	City of Harlan/HMU
Contact--Position/Office:	Human Resources
Address:	711 Durant St., Harlan, IA 51537
Phone Number:	(712) 755-5137

HIPAA SPECIAL ENROLLMENT NOTICE

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage (including Medicaid and State Child Health Coverage)
If you are declining coverage for yourself or your dependents (including 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 you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). Some plans may allow longer than 30 days, so please refer to your plan documents for your specific plan details.

> Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this health plan.

Marriage, Birth, or Adoption
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, or placement for adoption. Some plans may allow longer than 30 days, so please refer to your plan documents for your specific plan details.

> Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or State Child Health Coverage
If you or your dependents lose eligibility for coverage under Medicaid or State Child Health Coverage Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP or the determination of eligibility for a premium assistance subsidy.

> Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

WOMEN'S HEALTH & CANCER RIGHTS ACT OF 1998

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications at all stages of the mastectomy, including lymph edemas.

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under this plan.

NEWBORNS' AND MOTHER'S HEALTH PROTECTION ACT

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).

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Beginning in 2014, there is a new way to buy health insurance: The **Health Insurance Marketplace**. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Each year, the open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the previous year. After Dec. 15, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent (as adjusted each year after 2014) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (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 percent of such costs.)

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

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, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.