JANUARY 2024 – DECEMBER 2024

2024 BENEFITS ENROLLMENT

YOUR BENEFITS, YOUR STORY
Benefits to fit your unique situation

5 WAYS TO SAVE
On healthcare expenses

3 TIPS
For an easy enrollment

CITY OF WASHINGTON IOWA

TRUE NORTH
Insurance and Financial Strategies

YOUR BENEFIT OFFERINGS:

- Medical
- Dental
- Vision
- Short-Term Disability
- Long-Term Disability
- Life Insurance

THINGS TO KNOW

5 WAYS TO SAVE

1. THINK ABOUT HOW YOU WILL USE YOUR BENEFITS.

- Do you have a chronic condition?
- Do you have surgery planned for this year?
- Are you adding any new dependents to your plan?

Consider these questions when choosing a plan.

2. MANAGE MEDICATION COSTS.

Ask your doctor to prescribe you generic medications. They can be just as effective and typically cheaper!

3. TRY Doctor On Demand OR URGENT CARE.

Telemedicine and urgent care can cost you much less than going to the ER and usually save you a lot of time.

4. STAY IN-NETWORK FOR CARE.

Think of it as an exclusive club. You may pay higher amounts if you go Out-of-Network.

5. PREVENTION IS KEY.

Prevention is key to catching disease or illness early on. Plus, preventive exams are often free or cost less than a normal doctor's visit.

3 TIPS FOR EASY ENROLLMENT

1. DON'T WAIT!

As a new hire this is your one chance to choose your benefits until our annual enrollment period.

After this enrollment period, the only way you'll be able to change your plans before the following enrollment period is if you have a **qualifying life event,** such as getting married or having a baby.

2. TO ENROLL OR NOT TO ENROLL?

This year you are required to enroll in and/or waive your benefits.

3. UP YOUR BENEFITS IQ

Have questions about your benefit options? Not sure what is right for you? Don't forget about the TrueAdvocate Team! They are available from 7:30 a.m. - 5 p.m. CST to answer your benefits questions. Just call 888-655-9980 OR email trueadvocate@truenorthcompanies.com.

The plan information outlined in this enrollment guide is intended to be a snapshot of the benefits and does not provide full plan details. For complete plan information and any policy restrictions, refer to your plan document. If any discrepancy exists between the summary displayed in this guide and the policy, the policy will govern.

BENEFITS VOCABULARY

WELCOME TO YOUR 2024 BENEFITS!

To better understand your coverage, it's helpful to be familiar with **benefits vocabulary**. Take a moment to review these terms, which may be referenced throughout this guide.

Balance Bill – When a health care provider bills a patient for the difference between what the patient's health insurance chooses to reimburse and what the provider chooses to charge.

Copay – A fixed dollar amount you pay the provider at the time of service; for example, a $25 copay for an office visit or a $10 copay for a generic prescription.

Coinsurance – The percentage paid for a covered service, shared by you and the plan. Coinsurance can vary by plan and provider network. Review the plans carefully to understand your responsibility. You are responsible for coinsurance until you reach your plan's out-of-pocket maximum.

Deductible – The amount you pay each calendar year before the plan begins paying benefits. Not all covered services are subject to the deductible; for example, the deductible does not apply to preventive care services. Emergency Room Care – Care received at a hospital emergency room for life-threatening conditions.

In-Network Care – Care provided by contracted doctors within the plan's network of providers. This enables participants to receive care at a reduced rate compared to care received by out-of-network providers.

Out-of-Network Care – Care provided by a doctor or at a facility outside of the plan's network. Your out-of-pocket costs may increase and services may be subject to balance billing.

Out-of-Pocket Maximum – The maximum amount you pay per year before the plan begins paying for covered expenses at 100%. This limit helps protect you from unexpected catastrophic expenses.

Premium – The complete cost of your plans. You share this cost with your employer and pay your portion through regular paycheck deductions.

Preventive Care – Routine health care including annual physicals and screenings to prevent disease, illness, and other health complications. In-network preventive care is covered at 100%.

Urgent Care – Urgent care is not the same as emergency care. Visit urgent care for sudden illnesses or injuries that are not life-threatening.

Urgent care centers are helpful when care is needed quickly to avoid developing more serious pain or problems.

Preferred generic drugs – Generic drugs have the same active ingredients and work the same way as the brand-name drugs they copy. They usually cost less than the brand-name versions.

Preferred brand drugs – These drugs are included in a plan's list of covered drugs and may not have a generic version. They cost more than generic drugs but less than non-preferred brand drugs.

Specialty drugs – These drugs are used to treat ongoing health conditions and can be costly. They often require special handling and may have to be ordered through a specialty pharmacy.

BENEFITS 101

Deductible
Amount you pay for healthcare **BEFORE** your insurance starts to pay.

Coinsurance (aka Cost Share)
A **percentage** of the cost of care you are responsible to pay for **AFTER** you have met the deductible.

Co-Payment (aka Copay)
Fixed amount of money you pay each time you or your dependents receive care.

Out of Pocket Maximum (OPM)
Greatest amount of money you can spend on healthcare for the year.

- Does not include premiums or costs that your insurance plan does not cover.

DEDUCTIBLE
COINSURANCE
COPAYMENT

Out of Pocket Maximum

Partial Self-Funding

WHAT DOES THAT MEAN?

It means that City of Washington pays for a higher deductible plan from Wellmark ("Company Plan") but offers you a lower deductible plan ("Employee Plan"). This plan is lower in cost to you than other plans available through Wellmark.

To utilize a partially self-funded plan, we have contracted with a Third-Party Administrator named EBS.

Employee visits Doctor.

Doctor submits claim to Wellmark.

Wellmark sends Explanation of Benefits (**EOB**) **to doctor, EBS and employee** reflecting higher deductible "Company Plan."

EBS processes and adjusts EOB to reflect the lower deductible "Employee Plan."

EBS sends **revised EOB to doctor and employee.** Employee should **retain the EBS EOB.**

Doctor sends **invoice to employee.**

Employee pays remainder of Doctor's invoice.

Medical Plan

WELLMARK | 800-524-9242

WWW.WELLMARK.COM

HOW TO FIND A NETWORK PROVIDER.

1. Visit the site below, click **Search Now**.
2. Input your location and enter the first three letters on your ID card. Otherwise, click **Browse a list of plans.**
3. Select Wellmark Blue PPO

Provider Search: www.wellmark.com/member/find-provider

IN-NETWORK BENEFITS	PURCHASED PLAN	SELF-FUNDING DOWN TO
Deductible	$5,000 Single $15,000 Family	$1,000 Single $2,000 Family
Coinsurance	Plan pays 70%, you pay 30%	Plan pays 70%, you pay 30%
Out of Pocket Maximum	$10,000 Single $30,000 Family	$3,000 Single $6,000 Family
Office Visit Copay	$30 PCP $60 Specialist $30 Telemed	$30 PCP $60 Specialist $30 Telemed
Preventive Office Copay	Covered at 100%	Covered at 100%
Emergency Room Copay	$250 copay	$250 copay
Inpatient Hospital/ Outpatient Surgery	You pay 30% after deductible, plan pays 70%	You pay 30% after deductible, plan pays 70%
Prescription Drug		
Deductible	$100 Single / $200 Family	$100 Single / $200 Family
Tiers 1-4	(waived for Tier 1 drugs); then $8 / $35 / $50 / $85 Specialty $70 / $85	(waived for Tier 1 drugs); then $8 / $35 / $50 / $85 Specialty $70 / $85

PER PAY PERIOD	EMPLOYEE	EMPLOYEE + SPOUSE	EMPLOYEE + CHILDREN	FAMILY
RATES	$25.33	$129.69	$119.88	$194.35

Virtual Doctor Visits – Doctor On Demand

It's now easier than ever To meet your providers online. All you need is a smartphone, tablet, or computer/laptop to have a successful online doctor visit.

USE TELEMEDICINE WHEN:

- You don't have time to wait a week to see a doctor
- You don't want to infect (or be infected by) another person

USE TELEMEDICINE FOR:

- Urgent care issues like colds, coughs, and stomach aches
- Mental health treatment, including online therapy, counseling, and medication management
- Recurring conditions like migraines or urinary tract infections
- Skin conditions
- Prescription management

How To Register

1 BE READY TO ACCESS

To get started, visit DoctorOnDemand.com to **register and set up your account**

2 HAVE YOUR WELLMARK MEMBER ID CARD READY.

Enter your Wellmark ID number, including the three character prefix and five-digit group number

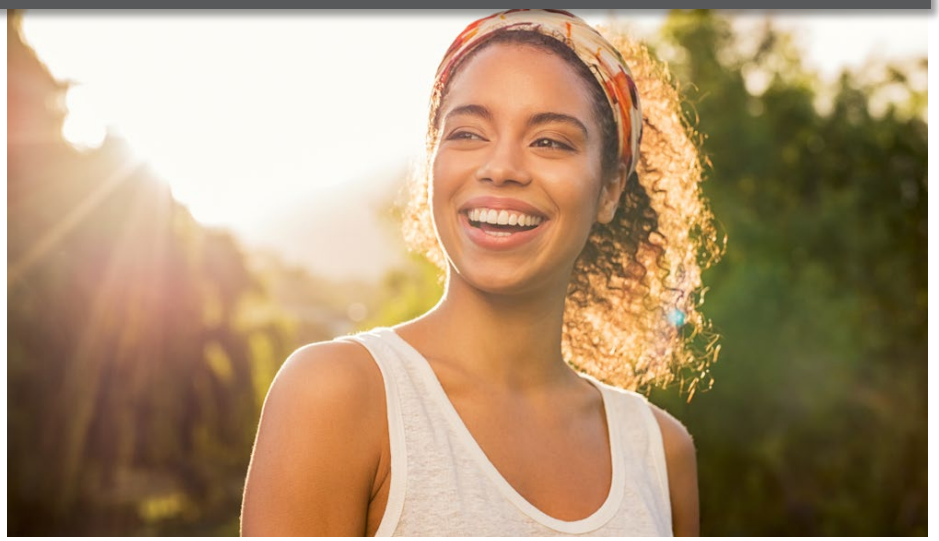
3 WHEN YOU NEED CARE

- download the Doctor on Demand app
- find a well-lit, private spot with good signal on your device

Dental Plan

WELLMARK | 800-524-9242

WWW.WELLMARK.COM



MEDICAL INSURANCE DOESN'T ALWAYS COVER OTHER TYPES OF CARE.

That's why we offer you the option to enroll in a separate dental plan. Please see a summary of your plan below and review the full plan summary or Certificate of Coverage for details.

HOW TO FIND A NETWORK PROVIDER.

1. Visit the site to the left, click **Find a dentist** (near the bottom.)
2. Choose from the **Blue Dental PPO** Network.

Provider Search:
www.wellmark.com/member/find-provider

SERVICES	PPO DENTIST
Preventive Services	80% covered
Deductible *	$25 Single / $75 Family
Basic Services	You pay 50% coinsurance (after deductible), plan pays 50%
Major Services	You pay 50% coinsurance (after deductible), plan pays 50%
Annual Maximum	$1,500 per person per year
Orthodontic For dependent children up to age 19	You pay 50% coinsurance (after deductible), plan pays 50% coinsurance, up to a lifetime maximum of $1,000

PER PAY PERIOD	EMPLOYEE	EMPLOYEE + SPOUSE	EMPLOYEE + CHILDREN	FAMILY
RATES	$13.04	$26.46	$25.03	$43.68

* Deductible is waived for diagnostic & preventive services

Vision Plan

AVESIS | 800-524-9242

WWW.MYAVESIS.COM

MEDICAL INSURANCE DOESN'T ALWAYS COVER OTHER TYPES OF CARE.

That's why we offer you the option to enroll in a separate vision plan. Please see a summary of your plan below and review the full plan summary or Certificate of Coverage for details.

HOW TO FIND A NETWORK PROVIDER.

1. Visit the site below and enter your zip code.
2. Search by your zip code, Provider's Last Name, or Office Name.

Provider Search:
www.fap.avesis.com/commercial/provider/search

SERVICES	IN-NETWORK MEMBER COST
Exam 1 every 12 months	$10
Contacts 1 every 12 months	**Please note:** Contact lenses are in place of lenses and frame. • $50 for elective contact lens exam • $50 copay for medically necessary contact lens exam (fitting and evaluation) • $150 for contact lenses • Medically necessary contact are covered in full
Frames 1 every 24 months	• $150 allowance and 20% off the amount over your allowance
Lenses 1 every 12 months	Most lenses are covered in full after copay • Single Lined • Bifocal Lined • Trifocal • Lenticular

PER PAY PERIOD	EMPLOYEE	EMPLOYEE + SPOUSE	EMPLOYEE + CHILDREN	FAMILY
RATES	$5.52	$10.60	$11.56	$14.86

Life and AD&D Rates

MUTUAL OF OMAHA | 800-775-8805

WWW.MUTUALOFOMAHA.COM

EMPLOYER-PAID LIFE AND AD&D

City of Washington provides full-time employees with a life insurance policy and accidental death and dismemberment (AD&D) insurance. City of Washington pays the full cost of this benefit and is provided by Mutual of Omaha. Contact Human Resources to update your beneficiary.

EMPLOYEE-PAID LIFE AND AD&D

You have the option to purchase a greater amount of Life and AD&D coverage. Decide whether this extra benefit is worth the cost of coverage for you and your family. To figure this out, ask a few questions:

How would your family's finances be affected if you died?

How much of your paycheck is used for monthly living expenses?

LIFE AND AD&D BENEFIT	
Life and Accidental Death & Dismemberment	**Employee:** $50,000 **Spouse:** $2,000 **Child:** $1,000

VOLUNTARY EMPLOYEE-PAID LIFE AND AD&D BENEFITS	
Employee	Increments of $10,000 up to $300,000 or 5 times earnings. **Guaranteed Issue** up to $50,000.
Spouse	Increments of $10,000 up to $50,000 or 100% of employee. **Guaranteed Issue** up to $25,000. **Only available if the employee enrolls in Voluntary Life
Children	Increments of $1,000 for children 6 months and older. **Maximum** benefit $10,000. **Minimum** benefit of $2,000 **Guaranteed Issue** up to $10,000.

Guaranteed Issue is the amount you can elect before you are required to complete a health questionnaire, otherwise known as **Evidence of Insurability (EOI)**.

Life and AD&D Rates

MUTUAL OF OMAHA | 800-775-8805
WWW.MUTUALOFOMAHA.COM

EMPLOYEE-PAID LIFE AND AD&D

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How much of your paycheck is used for monthly living expenses?

EMPLOYEE AGE	MONTHLY RATE PER $1,000
20-24	$0.06
25-29	$0.07
30-34	$0.08
35-39	$0.20
40-44	$0.31
45-49	$0.53
50-54	$0.87
55-59	$1.36
60-64	$2.13
65-69	$3.82
Child Rate per $1,000	$0.19
Voluntary AD&D	$0.03 per $1,000

Income Replacement

MUTUAL OF OMAHA | 800-775-8805
WWW.MUTUALOFOMAHA.COM

If you are unable to work, disability insurance can help replace your income so you can pay your bills and protect your savings.

EMPLOYER-PAID SHORT-TERM DISABILITY

Short-term disability pays a weekly benefit when you are unable to work for a certain amount of time.

EMPLOYER-PAID LONG-TERM DISABILITY

Long-term benefits usually take over when Short-term benefits end. This is often a monthly benefit, either a percentage of your salary or a flat amount.

BENEFITS*	SHORT-TERM	LONG-TERM
Coverage amount	66.67% of weekly income up to $900	60% of monthly income up to $5,000
Maximum payment period	9 weeks	Social Security Normal Retirement Age (SSNRA)
Accident benefits begin	Day 30	Day 90
Illness benefits begin	Day 30	Day 90

49111157

Employee Assistance Program

Available Services When You Need Help the Most

Life isn't always easy. Sometimes a personal or professional issue can affect your work, health and general well-being. During these tough times, it's important to have someone to talk with to let you know you're not alone.

With Mutual of Omaha's Employee Assistance Program, you can get the help you need so you spend less time worrying about the challenges in your life and can get back to being the productive worker your employer counts on to get the job done.

Learn more about the Employee Assistance Program services available to you.

We are here for you

Visit the Employee Assistance Program website to view timely articles and resources on a variety of financial, well-being, behavioral and mental health topics.

mutualofomaha.com/eap
or call us: 1-800-316-2796

Basic EAP Services

Features	Value to Company and Employees
Employee Family Clinical Services	• An in-house team of Master's level EAP professionals who are available 24/7/365 to provide individual assessments • Outstanding customer service from a team dedicated to ongoing training and education in employee assistance matters • Access to subject matter experts in the field of EAP service delivery
Counseling Options	• Three calls per year (per household) with our in-house Master's level EAP professionals, who will provide the caller with community resources • Additional community resources or possible counseling options come at the expense of the employee
Access	• 1-800 hotline with direct access to a Master's level EAP professional • 24/7/365 services available • Telephone support available in more than 120 languages • Online submission form available for EAP service requests

Continued on back.

Mutual of Omaha

Basic EAP Services *(continued)*

Features	Value to Company and Employees

Online Services	• An inclusive website with resources and links for additional assistance, including:
	  • Current events and resources
	  • Family and relationships
	  • Emotional well-being
	  • Financial wellness
	  • Substance abuse and addiction
	  • Legal assistance
	  • Physical well-being
	  • Work and career
	• Bilingual article library

Employee Family Legal Services	• Valuable resources available via website
	  • Legal libraries & tools
	  • Legal forms
	• 1 Legal consultation with an attorney per year (up to 30 minutes)
	  • 25% discount for ongoing legal services for same issue

Employee Family Work/Life Services	• Child care resources and referrals • Elder care resources and referrals
Employee Family Financial Services	• Inclusive financial platform powered by Enrich • Personal financial assessment tool • Personalized courses, articles & resource to meet financial needs • Ongoing progress reports on financial health
Employee Communication	• All materials available in English and Spanish
Eligibility	• Full-time employees and their immediate family members; including the employee, spouse and dependent children (unmarried and under 26) who reside with the employee
Coordination with Health Plan(s)	• EAP professionals will coordinate services with treatment resources/providers within the employee's health insurance network to provide counseling services covered by health insurance benefits, whenever possible

Re: Voluntary Supplemental Benefit Offerings

During Open Enrollment this year we will be offering voluntary supplemental benefits with Assurity. The Assurity benefits will be offered in place of the current Transamerica plans. The plans being offered with Assurity will be an Accident Plan, a Critical Illness Plan and a Hospital Plan. All the Assurity options will be offered on a Guaranteed to Issue basis with no health questions to enroll for you or your family. During the open enrollment meeting Supplemental Insurance Services will go over the new options, including plan benefits and cost. If you are currently enrolled in a Transamerica plan you will have the option to move your coverage to Assurity or continue directly with Transamerica. Supplemental Insurance Services will be available to answer questions during the open enrollment period. Below is a brief introduction to each plan.

Accident Plan- Even with a good health insurance plan, a trip to the doctor or hospital can be expensive. If you or someone in your family are hurt in an accident, the last thing you want to think about is how you are going to pay for medical care. Accident expense insurance provides peace of mind and gives you additional cash to help pay your health insurance deductible and other expenses. Group Accident Expense insurance pays a benefit directly to you when you receive treatment from a physician for a covered accident.

Critical Illness Plan- More people are surviving life threatening illnesses than ever before. Unfortunately, the cost of critical illness care is high and medical bills can follow survivors long after they've proven victorious in their fight. Critical illness insurance provides peace of mind and gives you additional cash to help pay your health insurance deductible and other out-of-pocket expenses. Group Critical Illness insurance pays a lump-sum benefit directly to you if you are diagnosed with stroke, heart attack or a number of other covered conditions.

Hospital Plan- A hospital stay can be expensive even with a good health insurance plan. Hospital indemnity insurance provides peace of mind and gives you additional cash to pay your health insurance deductible and other expenses resulting from a covered hospital stay. Group Hospital Indemnity insurance pays a benefit directly to you, starting at admission, for each day of hospital confinement.

Assurity®

Rates prepared for City of Washington Iowa on 10/31/23 4:05 PM
Iowa - Bi-Weekly Rates
Proposal - 238329

Group Accident Expense (Forms G H1708/G H1708C) (HSA Compatible)

24-Hour

	Coverage	Employee	Employee + Spouse	Employee + Children	Family
All Ages	Tier 3	$9.34	$16.22	$18.41	$27.42

Group Hospital Indemnity (Forms G H1730/G H1730C) (HSA Compatible)

Tier 2

	Employee	Employee & Spouse	Employee & Children	Family
All Ages	$10.57	$21.46	$20.39	$31.27

Premium rates shown are for the combined policy and rider benefits as summarized in the proposal. Rates provided are illustrative and your actual premium rate may be different depending on your particular situation and plan choices. The policy may contain reductions of benefits, limitations and exclusions. Product availability, features, provisions and rates may vary by state. For complete benefit descriptions, limitations, conditions and exclusions, ask to review the policy/certificate. Products are underwritten by Assurity Life Insurance Company, Lincoln, NE.

Group Critical Illness (Forms G H1715/G H1715C)(HSA Compatible)

Tier 2

Employee or Employee & Children - (rates based on employee's age; benefit amounts over $30,000 require underwriting of all covered persons)
Child benefit is equal to 25% of employee benefit.

Non-Tobacco		$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
Issue Age	18-24	$1.74	$2.97	$4.18	$5.40	$6.62	$7.85
	25-29	$2.23	$3.78	$5.32	$6.87	$8.41	$9.97
	30-34	$2.70	$4.66	$6.58	$8.55	$10.46	$12.42
	35-39	$3.63	$6.21	$8.79	$11.36	$13.95	$16.52
	40-44	$4.63	$7.95	$11.24	$14.55	$17.85	$21.16
	45-49	$5.94	$10.38	$14.82	$19.26	$23.71	$28.15
	50-54	$7.79	$13.90	$20.02	$26.15	$32.26	$38.38
	55-59	$10.19	$18.62	$27.06	$35.51	$43.93	$52.35
	60-64	$12.31	$23.03	$33.73	$44.43	$55.14	$65.85
	65-69	$15.87	$30.24	$44.62	$58.98	$73.35	$87.70
	70+	$25.63	$49.62	$73.63	$97.66	$121.66	$145.66

Tobaccco		$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
Issue Age	18-24	$2.13	$3.72	$5.34	$6.94	$8.53	$10.13
	25-29	$2.79	$4.92	$7.02	$9.14	$11.24	$13.38
	30-34	$3.58	$6.36	$9.13	$11.92	$14.70	$17.48
	35-39	$4.94	$8.84	$12.71	$16.60	$20.47	$24.36
	40-44	$6.52	$11.67	$16.82	$21.98	$27.12	$32.27
	45-49	$8.72	$15.88	$23.04	$30.19	$37.36	$44.51
	50-54	$11.87	$21.95	$32.06	$42.17	$52.26	$62.37
	55-59	$16.05	$30.22	$44.41	$58.58	$72.75	$86.93
	60-64	$19.82	$37.94	$56.01	$74.10	$92.22	$110.31
	65-69	$25.88	$50.12	$74.34	$98.58	$122.81	$147.05
	70+	$40.11	$78.44	$116.75	$155.05	$193.37	$231.69

Employee & Spouse or Family - (rates based on employee's age; benefit amounts over $30,000 require underwriting of all covered persons)
Spouse benefit is equal to 50% of employee benefit. Child benefit is equal to 25% of employee benefit..

Non-Tobacco		$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
Issue Age	18-24	$2.80	$4.57	$6.36	$8.16	$9.94	$11.72
	25-29	$3.50	$5.74	$8.00	$10.24	$12.51	$14.74
	30-34	$4.31	$7.13	$9.97	$12.79	$15.65	$18.47
	35-39	$5.79	$9.61	$13.38	$17.16	$20.97	$24.76
	40-44	$7.45	$12.33	$17.21	$22.10	$26.99	$31.88
	45-49	$9.51	$16.11	$22.72	$29.33	$35.93	$42.56
	50-54	$12.42	$21.54	$30.70	$39.82	$48.96	$58.08
	55-59	$16.10	$28.74	$41.35	$53.98	$66.60	$79.24
	60-64	$19.23	$35.29	$51.33	$67.38	$83.45	$99.49
	65-69	$24.56	$46.12	$67.67	$89.20	$110.77	$132.31
	70+	$39.24	$75.24	$111.26	$147.26	$183.27	$219.28

Tobaccco		$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
Issue Age	18-24	$3.37	$5.72	$8.10	$10.44	$12.80	$15.16
	25-29	$4.38	$7.47	$10.57	$13.66	$16.75	$19.84
	30-34	$5.60	$9.70	$13.78	$17.88	$21.99	$26.07
	35-39	$7.82	$13.56	$19.30	$25.04	$30.79	$36.52
	40-44	$10.31	$17.96	$25.60	$33.26	$40.91	$48.56
	45-49	$13.72	$24.39	$35.07	$45.76	$56.45	$67.12
	50-54	$18.56	$33.66	$48.78	$63.89	$79.00	$94.11
	55-59	$24.97	$46.21	$67.44	$88.69	$109.94	$131.19
	60-64	$30.58	$57.70	$84.83	$111.98	$139.11	$166.24
	65-69	$39.63	$75.98	$112.33	$148.67	$185.04	$221.37
	70+	$61.05	$118.53	$176.00	$233.46	$290.92	$348.40

Premium rates shown are for the combined policy and rider benefits as summarized in the proposal. Rates provided are illustrative and your actual premium rate may be different depending on your particular situation and plan choices. The policy may contain reductions of benefits, limitations and exclusions. Product availability, features, provisions and rates may vary by state. For complete benefit descriptions, limitations, conditions and exclusions, ask to review the policy/certificate. Products are underwritten by Assurity Life Insurance Company, Lincoln, NE.

DO YOU HAVE QUESTIONS ABOUT YOUR BENEFIT PROGRAMS AND AREN'T SURE WHO TO CONTACT?

The TrueNorth TRUEAdvocate Team is here to help!

Monday - Friday | 7:30 a.m. to 5:00 p.m. CT
For Spanish, please select option 4

Our team can assist with:

- Benefit coverage questions
- Ordering an ID card
- Claim questions and research
- Filing a claim
- Finding a provider
- Choosing a plan that works for you

(888) 655-9980

trueadvocate
@truenorthcompanies.com

CITY OF WASHINGTON IOWA

TRUE NORTH
Insurance and Financial Strategies

Important Notices from CITY OF WASHINGTON regarding the Group Health Plan

The following notices provide important information about the group health plan provided by your employer. Please read the attached notices carefully and keep a copy for your records.

If you have any questions regarding any of these notices, please contact:

General Contact and Plan Administrator

Name	Kelsey Brown
Phone	319-653-6584
Email	Kbrown@washingtoniowa.gov
Mailing Address	215 E Washington St. Washington, IA 52353

Distribution Date: January 2024

If applicable:

These notices are available via paper, free of charge, upon request to the Plan Administrator.

Please note this is not a legal document and should not be construed as legal advice.

Medicare Creditable Coverage Letter

Important Notice from CITY OF WASHINGTON 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 WASHINGTON 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 WASHINGTON has determined that the prescription drug coverage offered by the Group Health 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 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-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 WASHINGTON coverage may not be affected. If you do decide to join a Medicare drug plan and drop your current CITY OF WASHINGTON coverage, be aware that you and your dependents may 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 WASHINGTON 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 CITY OF WASHINGTON 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 ssa.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).

Women's Health and Cancer Rights Act Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 319-653-6584 for more information.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the 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. If you would like more information on WHCRA benefits, call your plan administrator at 319-653-6584.

Newborns' and Mothers' 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).

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your state for more information on eligibility.

ALABAMA – Medicaid

Website: http://myalhipp.com
Phone: 855-692-5447

ALASKA – Medicaid

The Alaska Health Insurance Premium Payment Program
Website: http://myakhipp.com
Phone: 866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid

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

CALIFORNIA – Medicaid

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

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com/
HIBI Customer Service: 855-692-64422

FLORIDA – Medicaid

Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 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

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip
Phone: 877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid
Phone 800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 800-257-8563
HIPP Website:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov
Phone: 800-792-4884
HIPP Phone: 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: 855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov
Phone: 877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid

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

MAINE – Medicaid

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

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 800-862-4840
TTY: 771
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 800-657-3739

MISSOURI – Medicaid

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

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

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

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 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: 800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org
CHIP Phone: 800-701-0710

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid
Phone: 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: 844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 888-365-3742

OREGON – Medicaid

Website: http://healthcare.oregon.gov
Phone: 800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website:
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 800-692-7462
CHIP Website:
https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: https://eohhs.ri.gov/
Phone: 855-697-4347, or 401-462-0311
(Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov
Phone: 888-549-0820

SOUTH DAKOTA – Medicaid

Website: https://dss.sd.gov/medicaid/default.aspx
Phone: 888-828-0059

TEXAS – Medicaid

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

UTAH – Medicaid and CHIP

Medicaid Website: https://medicaid.utah.gov
CHIP Website: https://chip.health.utah.gov
Phone: 877-543-7669

VERMONT– Medicaid

Website:
https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 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: 800-432-5924

WASHINGTON – Medicaid

Website: https://www.hca.wa.gov
Phone: 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: 855-MyWVHIPP
(855-699-8447)

WISCONSIN – Medicaid and CHIP

Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 800-362-3002

WYOMING – Medicaid

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

To see if any other states have added a premium assistance program since July 31, 2023, 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
https://www.cms.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

Patient Protection Notice

Wellmark of Iowa 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. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kelsey Brown at 319-653-6584.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Wellmark of Iowa or from any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Kelsey Brown at 319-653-6584.

HIPAA Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

If not attached to this document, you may request a copy of the current Privacy Practices, explaining how medical information about you may be used and disclosed and how you can get access to this information.

As Required by Law. We will disclose Health Information when required to do so by international, federal, state, or local law.

You have the right to:

- Inspect and copy records
- Receive an electronic copy of electronic medical records
- Get notice of a breach
- Amend records
- Receive an accounting of disclosures
- Request restrictions
- Request confidential communications
- Receive a paper copy of this notice
- File a complaint if you believe your privacy rights have been violated

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

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

Get a copy of health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

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

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

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

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

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

We can use and disclose your information to run our organization and contact you when necessary.

We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

	Example: We use health information about you to develop better services for you.
Pay for your health services	We can use and disclose your health information as we pay for your health services. *Example: We share information about you with your dental plan to coordinate payment for your dental work.*
Administer your plan	We may disclose your health information to your health plan sponsor for plan administration. *Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

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

Help with public health and safety issues	We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	We can use or share your information for health research.
Comply with the law	We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law

• For special government functions such as	military, national security, and presidential protective services
Respond to lawsuits and legal actions	We can share health information about you in response to a court or administrative order, or a subpoena.

Our Responsibilities

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

For more information see: www.hhs.gov/hipaa/for-individuals/notice-privacy-practices/index.html.

Changes to the Terms of this Notice

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

Other Instructions for Notice

- Insert Effective Date of this Notice
- Insert name or title of the privacy official (or other privacy contact) and his/her email address and phone number.
- Insert any special notes that apply to your entity's practices such as "we do not create or manage a hospital directory" or "we do not create or maintain psychotherapy notes at this practice."
- The Privacy Rule requires you to describe any state or other laws that require greater limits on disclosures. For example, "We will never share any substance abuse treatment records without your written permission." Insert this type of information here. If no laws with greater limits apply to your entity, no information needs to be added.
- If your entity provides patients with access to their health information via the Blue Button protocol, you may want to insert a reference to it here.
- If your entity is part of an OHCA (organized health care arrangement) that has agreed to a joint notice, use this space to inform your patients of how you share information within the OHCA (such as for treatment, payment, and operations related to the OHCA). Also, describe the other entities covered by this notice and their service locations. For example, "This notice applies to Grace Community Hospitals and Emergency Services Incorporated which operate the emergency services within all Grace hospitals in the greater Dayton area."

Notice of Special Enrollment Rights

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

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

To request special enrollment or obtain more information, contact Kelsey Brown at 319-653-6584.

Continuation Coverage Rights Under COBRA

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

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

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA continuation coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an eight-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of

Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

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

Plan contact information

Kelsey Brown at 319-653-6584.

For the Department of Labor's Employer Exchange/Marketplace Notices and Instructions, visit: http://www.datair.com/PDF/DOL Employer Exchange Notices.pdf

New Health Insurance Marketplace Coverage Options and Your Health Coverage | For Employers that Offer a Health Plan to Some or All Employees

PART A: General Information

When key parts of the health care law took effect in 2014, a new option for health insurance was made available: the Health Insurance Marketplace Exchange. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

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. Open enrollment for health insurance coverage through the Marketplace begins in October for coverage starting as early as January 1.

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% 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 Kelsey Brown.

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

OMB No. 1210-0149 (expires 9-30-2023)

PART B: Information About Health Coverage Offered by Your Employer

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

<table>
<tr><td colspan="2">3. Employer name City of Washington</td><td colspan="2">4. Employer Identification Number (EIN)</td></tr>
<tr><td colspan="2">5. Employer address– 215 E Washington Street</td><td colspan="2">6. Employer phone number 319–653–6584</td></tr>
<tr><td>7. City– Washington</td><td>8. State– IA</td><td colspan="2">7. Zip code– 52353</td></tr>
<tr><td colspan="4">10. Who can we contact about employee health coverage at this job? Kelsey Brown</td></tr>
<tr><td colspan="2">11. Phone number (if different from above)</td><td colspan="2">12. Email address Kbrown@washingtoniowa.gov</td></tr>
</table>

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

As your employer, we offer a health plan to:

☑ All employees. Eligible employees are:

All eligible full time employees.

With respect to dependents:

☑ We do offer coverage. Eligible dependents are:

Spouses, natural child, legally adopted or placed for adoption child, child for whom member has legal guardianship, stepchild.

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

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

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

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're *never* required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
- Cover emergency services without requiring you to get approval for services in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact Kelsey Brown. The federal phone number for information and complaints is 1-800-985-3059.

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Visit https://iid.iowa.gov/no-surprises-act for more information about your rights under Iowa state laws.