Gillett School District Employee Benefits Guide Template Acknowledgement

M3 Insurance Solutions, Inc. (M3) has prepared the Employee Benefits Guide template to assist your organization in educating employees on health and welfare insurance benefits placed by M3. This template does not include all terms, coverages, exclusions, limitations, and conditions of applicable plan(s) contract language.

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We encourage you to review/edit/utilize all included content at your discretion. If necessary, please consult with your employee benefits attorney regarding program compliance.

By deleting or removing this page, you acknowledge that your organization assumes full responsibility of the content that is provided to your employee population.

Gillett School District

2025-2026 Employee Benefits Guide

QUESTIONS?

Lynda Zeitler: (920) 855-2137 | lzeitler@gillett.k12.wi.us

Benefits Enrollment Checklist

This guide will help you get to know your benefits and your choices for the 2024-2025 plan year. Be sure to learn about your options so you can make informed choices for yourself and your eligible dependents.

IN THE FIRST 30 DAYS

Enroll in these plans or waive coverage:

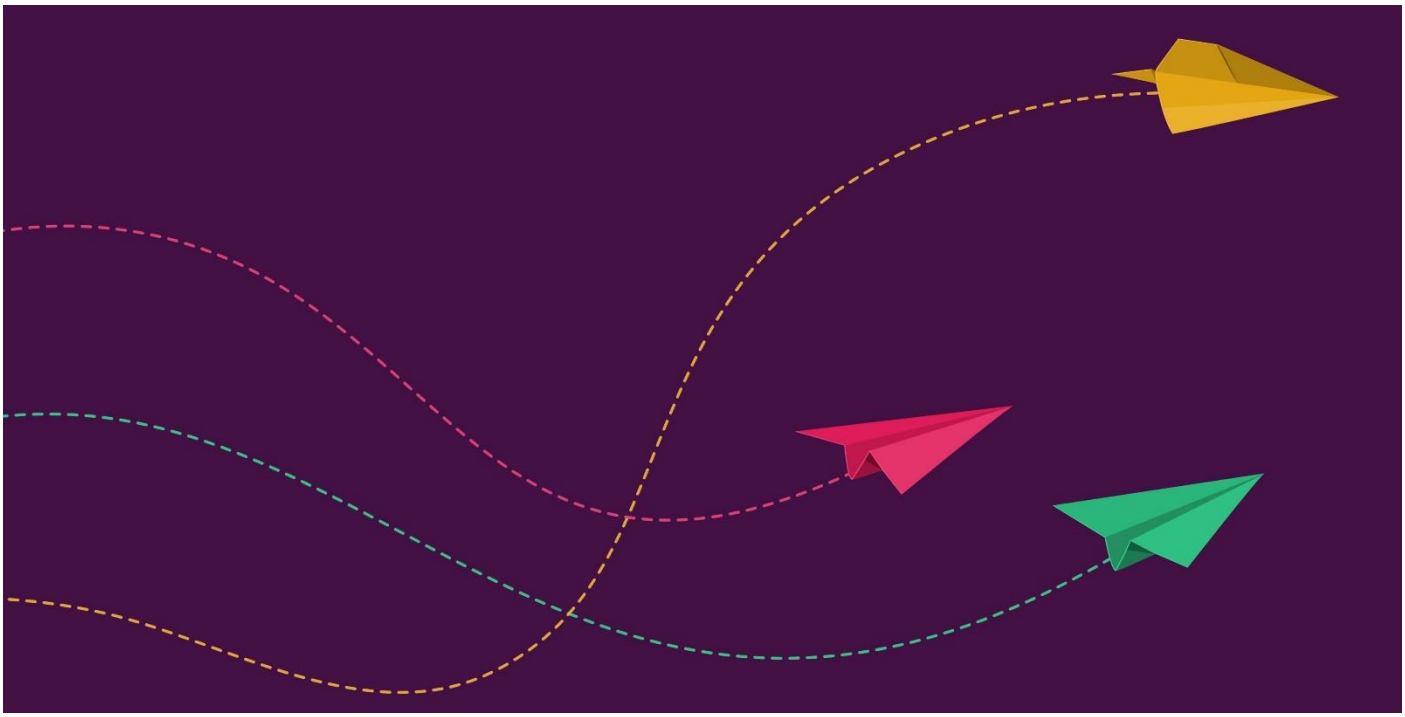
- ☐ Medical
- ☐ Dental
- ☐ Vision
- ☐ Flexible Spending Arrangement
- ☐ Life and AD&D Coverage
- ☐ Short Term and Long-Term Disability

Carrier Contacts

Coverage	Carrier	Contact
Medical	WCA Group Health Trust	866.404.2700 www.wcaght.org
FSA Benefit	EBC	800.346.2126 www.ebcflex.com
Dental & Vision	Delta Dental	800.236.3712 www.deltadentalwi.com
Life, STD, & LTD	The Standard	888.937.4783 www.standard.com
Employee Assistance Program	The Standard	888.293.6948 www.healthadvocate.com/standard3

For questions and forms contact

- **Lynda Zeitler (920) 855-2137 or lzeitler@gillett.k12.wi.us**



Medical Plan

Medical Plan

You get the most from your benefits when you take the time to learn about your options and make decisions that are best for you and your family. Gillett School District provides eligible employees coverage with the WCA Group Health Trust.

You have access to providers participating in the UHC Choice Plus network. Find a participating health care provider in your area by going to: UMR.com.

Refer to the Summary of Benefits Coverage (SBCs) for detailed medical plan coverage information.

Eligibility

- All full-time employees

And Your...

- Spouse
- Biological children, stepchildren, legally adopted children (effective from the placement date for adoption), and foster children up to age 26.

Terms To Know

Deductible

The amount ***you pay*** out of your pocket each year ***before the plan begins*** sharing costs for most services. Payments to in-network and out-of-network providers count toward your annual deductible and annual out-of-pocket maximum.

Copay

The dollar amount you must pay for certain covered services. Payments count toward your annual out-of-pocket maximum but ***not*** toward your deductible.

Out-of-Pocket Maximum

The most you'll have to pay out of your pocket in a calendar year for covered services.

Coinsurance

The cost share between you and the plan after you meet the calendar year deductible. In other words, after you meet your deductible, you share any remaining covered expenses with the plan. The plan covers the percentage of the expense shown.

Medical Plan Highlights

WCA Group Health Trust Network: UHC Choice Plus	HMO | $1,000 / $2,000 Deductible	
	In-Network	**Out-of-Network**
Deductible		
Single	$1,000	N/A
Family	$2,000	N/A
Out-of-Pocket Maximum		
Single	$3,000	N/A
Family	$6,000	N/A
Coinsurance	90%	N/A
Physician Services		
Routine / Preventive Care	***Select Services Are FREE***	N/A
Virtual Care	$0 Copay	N/A
Primary Care Physician	$25 Copay/Ded/Coins	N/A
Specialist	$50 Copay/Ded/Coins	N/A
Hospital Services	Deductible & Coinsurance	N/A
Urgent Care | ER		
Urgent Care	$100 Copay/Ded/Coins	N/A
Emergency Care	$250 Copay/Ded/Coins	$250 Copay/Ded/Coins
Prescription Drugs		
Retail (30 Days)	$0 / $10 / $30 / $60 / $100	
Mail Order (90 Days)	$0 / $20 / $60 / $120	
Rx Out-of-Pocket Maximum	$2,000 person / $4,000 family	
Vision Exam	100%, Deductible Waived (1st Exam of Calendar Year)	

***** Separate prescription drug out-of-pocket maximum: $2,000 person / $4,000 family. This is in addition to the maximum out of pocket *****

Refer to the Summary Plan Descriptions (SPDs) or Summary of Benefits Coverage (SBCs) for detailed medical plan coverage information.

EMPLOYEE PREMIUM CONTRIBUTIONS EFFECTIVE JULY 1, 2024

Employee Premiums	Monthly Cost
Employee	$109.25
Family	$247.26

Understanding Your Care Options

Proactively understanding your care options can have a big impact in the amount you pay out-of-pocket when seeking care. The chart below is intended to help you identify the right setting for your specific needs.

Type of Care	Common Services		Approximate Wait Time	Average Member Cost
Virtual Care	○ Colds or flu ○ Bronchitis ○ Respiratory infection ○ Pink eye	○ Sinus problems ○ Allergies ○ Urinary tract infection ○ Poison ivy	**15-20** Minutes	**FREE**
Your Doctor's Office	○ Preventative services ○ Vaccinations	○ Medical problems that are not an immediate, serious threat to your health or life	**1 Week** or More	**$**
Urgent Care	○ Sprains or strains ○ Mild asthma attack ○ Sore throat ○ Earaches	○ Minor broken bone ○ Minor cut ○ Minor infection ○ Minor rash	**20 – 30** Minutes	**$$**
Emergency Room	○ Sudden change in vision ○ Sudden trouble talking ○ Large open wounds ○ Major burn	○ Severe head injury ○ Heavy bleeding ○ Chest pain ○ Major broken bone	**3 – 12** Hours	**$$$**

You've got Teladoc Health

Teladoc HEALTH | GHT WCA Group Health Trust

Access to quality care at your fingertips

General Medical
free/visit

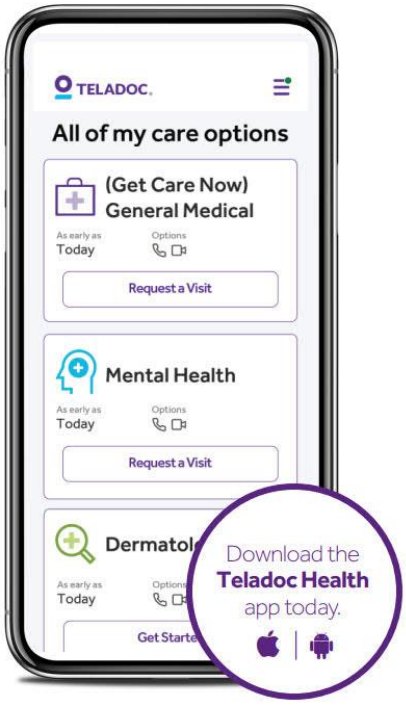
Talk to a licensed doctor for non-emergency conditions 24/7
Flu • Sinus infections • Sore throats • And more

Mental Health
free/ therapist visit
free/ psychiatrist first visit
free/ psychiatrist ongoing visit

Talk to a therapist 7 days a week

Dermatology
free / consult

Upload images of a skin issue online and get a custom treatment plan within two days
Eczema • Acne • Rashes • And more



Set up your account or log in today

Visit Teladoc.com

Call 1-800-TELADOC (835-2362) | Download the app

Refer to your employee booklet at umr.com for Teladoc benefits

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Group ID: 130295

Flexible Spending Account (FSA)

With an FSA, you can set aside tax-free money to pay for eligible medical and dependent care expenses. When you participate in an FSA, you decide how much you want to contribute each plan year (July 1 through June 30). The money you contribute is deducted from your pay before taxes are taken out. ***This lowers your taxable income, which means lower taxes for you!***

Gillett School District offers two types of FSAs administered by EBC.

Traditional Health Care FSA

You can use this FSA to pay any qualified health care expense, including copays and deductibles, dental care and vision care. You're ***not*** eligible for the Traditional Health Care FSA if you are currently contributing to a Health Savings Account.

Traditional Health Care FSA Contribution Limits

Gillett School District follows the indexed contribution limits set for this type of account by the Internal Revenue Service (IRS). The contribution limits for the Traditional Health Care FSA work on an individual employee/financial representative basis. The individual maximum is $3,200. However, if you and your spouse are both eligible for the same employer's FSA, you can each contribute separately to have your own $3,200 cap.

For the 2024-2025 plan year the district will be matching $250 into your Traditional Health Care FSA, as long as you contribute $250 or more. The amount will be pro-rated for mid-year enrollments.

Dependent Care FSA

The Dependent Care FSA covers the eligible day care expenses for your tax-qualified dependent(s). This can include a tax-qualified dependent under the age of 13 or an elderly parent or spouse who is physically or mentally incapable of self-care and lives with the account owner.

Unmarried individuals and married couples who file a joint tax return can contribute up to a maximum of $5,000 per year. Individuals who are married and file taxes separately can contribute up to a maximum of $2,500. You cannot contribute more than you or your spouse earned in income for the year. ***If you're enrolling during the year, you may not be eligible to make the maximum contribution to your FSAs. Talk to your tax advisor before signing up for pretax deductions. See IRS Publication 502 for more information.***

Dental Plan Highlights

Healthy teeth and gums are an important part of maintaining your overall health. That's why Gillett School District offers a dental plan administered by Delta Dental.

Delta Dental	
Individual Annual Maximum	**$1,000**
Deductible	
Employee Only	$0
Family	$0
Preventive Care Services	
Exams	100%
Cleanings	100%
Fluoride Treatments	100%
X-Rays	100%
Space Maintainers	80%
Sealants	100%
Emergency Treatment to Relieve Pain	100%
Basic Restorative Services	
Fillings	80%
Endodontics – Surgical / Non-Surgical	80%
Periodontics – Surgical / Non-Surgical	80%
Extractions – Surgical / Non-Surgical and other oral surgery	80%
Major Restorative Services	
Crowns, Inlays, Onlays	80%
Bridges and Dentures	50%
Repairs and Adjustments to Bridges and Dentures	80%
Implants	50%
Orthodontic Services	
Coinsurance	50%
Individual Lifetime Maximum	$1,500
Dependents Eligible to Age	26
Full-Time Students Eligible to Age	26

The District pays 100% of the dental premium for all eligible employees, so there is no cost to you!

Delta Dental Plan Programs & Value Adds

Save Money by Staying in the Network

You may seek dental care from any provider; however, your out-of-pocket expenses will be greatly reduced if care is provided by a dentist in the Delta Dental network. For more details or to find a provider in the network, visit www.deltadentalwi.com or call 1-800-236-3712.

Evidence Based Integrated Care*

Your dental plan includes Evidence-Based Integrated Care Plan, which offers additional cleanings and fluoride treatment for certain medical conditions, such as periodontal disease, heart disease, diabetes, and cancer-related treatments. You will need to self-register for the benefit by calling Delta Dental's customer service team, or you can register on the member portal. It's very simple to enroll, and proof of condition is not required.

Check Up Plus*

Your dental plan also includes a feature called Check Up Plus. With Check Up Plus, diagnostic and preventive services don't count against your individual annual maximum! So, you will have more of your annual maximum available if you do need basic and/or restorative care.

Vision Care Discount*

Delta Dental of Wisconsin has partnered with EyeMed Vision Care, to offer you savings on optical costs (up to 35%), with access to thousands of private practice and retail providers nationwide.

Amplifon Hearing Discount*

Delta Dental has partnered with Amplifon to provided member with resources for hearing aids, including access to an Amplifon Hearing Health Care discount card, custom hearing solutions, continuous care, and a risk-free 60 day trial.

*Please see attached flyers for more information.

Vision Plan Highlights

Your eyes provide doctors with a clear picture of your overall health. A comprehensive eye exam can identify serious medical problems such as high blood pressure, diabetes, heart disease and much more. That's why Gillett School District provides vision care administered by Delta Vision.

Delta Vision	In-Network	Out-of-Network
Frequency		
Vision Exam	Once per 12 months	
Frame	Once per 12 months	
Lenses	Once per 12 months	
Contact Lenses	Once per 12 months	
Vision Benefits	***$20 Copayment Then***	***Plan Pays Up To***
Vision Examination	100%	$35
Retail Frames	$150 Allowance, then 20% off amount over allowance	$75
Lens Benefit	***$20 Copayment Then***	***Plan Pays Up To***
Single Vision	100%	$25
Bifocal	100%	$40
Trifocal	100%	$55
Contact Lenses*		***Plan Pays Up To***
Lens Fitting/Evaluation	Up to $40 Copay	No Coverage
Medically Necessary	Paid in Full	$200
Conventional Contacts	$20 Copay, $150 Allowance, then 15% off amount over allowance	$120

**Covered in lieu of lenses & frame benefit*

EMPLOYEE PREMIUM CONTRIBUTIONS EFFECTIVE JULY 1, 2024

Monthly Premiums	Employee Cost
Employee	$5.64
Family	$14.04

Protection Plans

Voluntary Short Term Disability (STD)

Gillett School District's Short Term Disability plan is administered by The Standard. This benefit pays a *weekly* percentage of your salary if you become temporarily disabled, meaning that you are not able to work for a short period of time due to sickness or injury.

The Standard	Benefit Highlights
Premium	Employee Paid
Weekly Benefit	Choice of Benefit Options $147 - $504
Sickness Benefit Begins On	4th Day
Accident Benefit Begins On	1st Day
Maximum Benefit Duration	90 Days

Weekly Benefit	Monthly Premium
$147	$10.31
$175	$12.02
$224	$15.46
$273	$18.98
$301	$20.63
$357	$24.64
$420	$28.67
$462	$31.54
$504	$34.40

Long Term Disability (LTD)

Gillett School District's Long Term Disability plan is administered by The Standard and paid for by Gillett School District. This benefit pays a *monthly* percentage of your salary if you become disabled and are unable to work for an extended period of time.

The Standard	Benefit Highlights
Premium	Employer Paid
Monthly Benefit	90% to $9,450
Elimination Period	90 Days
Maximum Benefit Duration	Social Security Normal Retirement Age

NOTE: *Both the STD and LTD include pre-existing condition limitations. Please review the plan summaries for more details. Earnings for STD and LTD benefits are based on your base annual earnings and do not include other income such as bonuses and commissions.*

Protection Plans (continued)

Group Term Life and Accidental Death & Dismemberment (AD&D)

Life Insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump payment if you pass away while employed by Gillett School District. As an eligible employee, Gillett School District will partially supplement the cost of this coverage.

Gillett School District offers a Group Term Life Insurance benefit of 1 times your annual earnings plus accidental death and dismemberment insurance coverage. Specific details of the plan are covered in the Plan Certificate.

The Standard Plan Highlights

Premium	District will partially supplement the cost of this coverage.
Amount of Life Insurance Benefit	1 times your annual earnings
Amount of AD&D Benefit	Equal to term life

The Standard Add-Ons

Employee Assistance Program (EAP)

You, your dependents (including children to age 26) and all household members can contact masters- degreed clinicians 24/7 by phone, online, live chat, email and text. There is even a mobile EAP app. Receive referrals to support groups, a network counselor, community resources or your health plan. If necessary, you will be connected to emergency services. Your program includes up to three face-to-face assessment and counseling sessions per issue. EAP services can help with:

- Depression, grief, loss and emotional well-being
- Family, marital and other relationship issues
- Life improvement and goal-setting
- Addictions such as alcohol and drug abuse
- Stress or anxiety with work or family
- Financial and legal concerns
- Identity theft and fraud resolution

Life Services

Life Services Toolkit website:

- Estate-planning Assistance: Online tools walk employees through the steps to prepare a will and create other documents, such as living wills, powers of attorney and healthcare agent forms.
- Identity Theft Prevention: Online resources help employees learn how to thwart identity thieves and resolve issues if identity theft occurs.
- Financial Planning: Online tools help employees confidently manage debt, calculate mortgage and loan payments, and take care of other financial matters.
- Health and Wellness: Timely articles about nutrition, stress management and wellness help employees and their families lead healthy lives.
- Funeral Arrangements: Employees can use the website to calculate funeral costs, find funeral-related services and make decisions about funeral arrangements in advance.

Travel Assistance

Travel Assistance is available when you travel more than 100 miles from home or internationally for up to 180 days for business or pleasure. It offers aid before and during your trip.

A helping hand when you need it.

Rely on the support, guidance and resources of your Employee Assistance Program.

There are times in life when you might need a little help coping or figuring out what to do. Take advantage of the Employee Assistance Program,[1] which includes WorkLife Services and is available to you and your family in connection with your group insurance from Standard Insurance Company (The Standard). It's confidential — information will be released only with your permission or as required by law.

Connection to Resources, Support and Guidance

You, your dependents (including children to age 26)[2] and all household members can contact the program's master's-level counselors 24/7. Reach out through the mobile EAP app or by phone, online, live chat, and email. You can get referrals to support groups, a network counselor, community resources or your health plan. If necessary, you'll be connected to emergency services.

Your program includes up to three counseling sessions per issue. Sessions can be done in person, on the phone, by video or text.

EAP services can help with:

- Depression, grief, loss and emotional well-being
- Family, marital and other relationship issues
- Life improvement and goal-setting
- Addictions such as alcohol and drug abuse
- Stress or anxiety with work or family
- Financial and legal concerns
- Identity theft and fraud resolution
- Online will preparation and other legal documents

Contact **EAP**

888.293.6948
(TTY Services: 711)
24 hours a day,
seven days a week

healthadvocate.com/standard3

NOTE: It's a violation of your company's contract to share this information with individuals who are not eligible for this service.

With EAP, personal assistance is immediate, confidential and available when you need it.

WorkLife Services

WorkLife Services are included with the Employee Assistance Program. Get help with referrals for important needs like education, adoption, daily living and care for your pet, child or elderly loved one.

Online Resources

Visit **healthadvocate.com/standard3** to explore a wealth of information online, including videos, guides, articles, webinars, resources, self-assessments and calculators.

1 The EAP service is provided through an arrangement with Health Advocate℠, which is not affiliated with The Standard. Health Advocate℠ is solely responsible for providing and administering the included service. EAP is not an insurance product and is provided to groups of 10–2,499 lives. This service is only available while insured under The Standard's group policy.

2 Individual EAP counseling sessions are available to eligible participants 16 years and older; family sessions are available for eligible members 12 years and older, and their parent or guardian. Children under the age of 12 will not receive individual counseling sessions.

Standard Insurance Company | 1100 SW Sixth Avenue, Portland, OR 97204 | **standard.com**

DELTA DENTAL®

Smarter Dental Plans

Enhanced dental benefits for those who need them most.

Your dental coverage includes Delta Dental of Wisconsin's Evidence-Based Integrated Care Plan (EBICP), which provides **additional cleaning(s) and/or fluoride treatments to individuals with specific medical conditions** that have oral health implications. Enhanced benefits can play an important role in the management of certain medical conditions.

If you or an individual on your plan have one or more of these conditions, you can enroll online. Once you enroll, you are immediately eligible for EBICP benefits.

how to enroll

1. Go to **www.deltadentalwi.com**.
2. Select the purple "Sign In" button and enter your Username & Password.
3. On your dashboard under "Preventive Care and Plan Features" there will be a section for Additional Benefits. Select "Enroll Now."*
4. In the "Enroll in EBICP" section, select the member and their condition, verify the information, and hit "Select."
5. This member will then be listed under "Your Current EBICP Benefits."

Condition	Additional cleaning(s)	Topical fluoride
Cancer-related treatments	✓	✓
Weakened immune systems	✓	✓
Periodontal (gum) disease*	✓	✓
High-risk cardiac conditions	✓	
Kidney failure or dialysis	✓	
Diabetes	✓	
Pregnancy	✓	

This chart provides a brief summary of additional benefits to persons enrolled in EBICP. Frequency limitations may apply. Refer to your handbook.

**Periodontal cleanings may fall under basic services and may not be covered 100% by the EBICP plan. If you have questions regarding coverage for periodontal cleanings, please contact the Benefit Center at 800-236-3712 before services are performed.*

Connect With Us

*If your plan does not include EBICP, "Additional Benefits" will not show.

www.deltadentalwi.com

SS300H-1905

DELTA DENTAL

Smarter Dental Plans

CheckUp Plus™

Our CheckUp Plus™ plan option allows enrollees to get diagnostic and preventive dental services without those costs getting applied to the individual annual maximum. Preventive care saves money over the long-term by reducing the need for more expensive services.

CheckUp Plus™ lets you keep your annual maximum for the things you need, not the things you deserve.

The charts show the impact of CheckUp Plus™ on an enrollee's individual annual maximum compared to a traditional plan. Example assumes two routine check-ups, covered at 100% and a $1,000 annual maximum.

	CheckUp Plus™	Traditional Dental Plan
Delta Dental Pays	$300	$300
Enrollee Pays	$0	$0
Maximum Remaining	$1,000	$700

Plan benefit and dentist charges vary.

Connect With Us

www.deltadentalwi.com

SS300F-1805

Vision Care Discount

A Vision Discount Program is included with your Delta Dental plan.

Delta Dental of Wisconsin has chosen EyeMed Vision Care® as the network provider for your vision care discount program. This is not insurance, but a discount plan that provides:

- Overall savings up to 35%.
- Access to thousands of private practice and retail providers nationwide.
- Choice of any product, including designer brand-name frames (certain brands impose a no-discount policy and the frame discount is not available).
- Savings on laser vision correction.
- Replacement contact lenses by mail.

accessing your benefits

Receiving your vision care discount is easy.

1. Locate an EyeMed Vision Care provider using the provider search on our website at **www.deltadentalwi.com/vision**. Choose the Access Network. Or call EyeMed at **866-246-9041** (toll-free).
2. When scheduling an appointment, inform the office that you have a vision discount plan through the EyeMed Access panel of providers.
3. When you arrive for your appointment, present the enrollee card below to receive services.

This is a discount plan. It is not insurance. This discount plan may not be combined with any other discounts, promotional offers, or insurance coverage, and does not apply to EyeMed provider's professional services, or contact lenses.

Vision Care Discount Program Enrollee Cards

(Please detach cards for use)

EyeMed Group Number: 9231093
Group Name: Delta Dental Vision Discount Program
Name:

For provider information, go to www.deltadentalwi.com/vision. Choose the Access network. Or call EyeMed Vision Care at 866-246-9041.

This is a discount plan. It is NOT insurance.

EyeMed Group Number: 9231093
Group Name: Delta Dental Vision Discount Program
Name:

For provider information, go to www.deltadentalwi.com/vision. Choose the Access network. Or call EyeMed Vision Care at 866-246-9041.

This is a discount plan. It is NOT insurance.

Vision Discount Program	Cost/Savings
Exam (with dilation as necessary)	$5 off comprehensive exam/ $5 off contact-lens exam
Complete Pair of Glasses The following discounts and fees for frames, lenses, and lens options apply only if a complete pair is purchased in the same transaction. Items purchased separately will be discounted 20% off of the retail price.	
Frames (any frame available at provider location)	35% off retail price
Single Plastic Lenses (including standard scratch coating)	Member Pays:
Single-Vision	$50
Bifocal	$70
Trifocal	$105
Lens Options	Member Pays:
UV Coating	$15
Tint (solid and gradient)	$15
Standard Polycarbonate	$40
Standard Anti-Reflective Coating	$45
Standard Progressive (add-on to bifocal)	$65
Conventional Contact Lenses (materials only)	15% off retail price
Laser Vision Correction (LASIK or PRK)	15% off retail price or 5% off promotional price
Frequency (exams, frames, lenses, and contact lenses)	Unlimited

additional notes

- After initial purchase, replacement contact lenses may be obtained online at substantial savings and mailed directly to the member.
- Receive 20% discount on items purchased at participating providers not included under the program. 20% discount may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed provider's professional services, or contact lenses.
- Retail prices may vary by location.

plan limitations/exclusions:

- Orthoptic or vision training, subnormal vision aids, and associated supplemental testing
- Medical and/or surgical treatment of the eye, eyes, or supporting structures
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear
- Services provided as a result of any Worker's Compensation law
- Plano non-prescription lenses and non-prescription sunglasses (except for 20% discount)

SS325-1911

Vision Care Discount Program Enrollee Cards

(Please detach cards for use)

Locate an EyeMed provider convenient to you at:

www.deltadentalwi.com/vision

866-246-9041

When scheduling an appointment, inform the provider that you have a vision discount plan through the **EyeMed Access** panel of providers, with Delta Dental of Wisconsin.

At the time of your appointment, remind the provider that you have a vision discount plan through the **EyeMed Access Plan**.

Providers: This is NOT insurance - it is a vision discount plan.

Locate an EyeMed provider convenient to you at:

www.deltadentalwi.com/vision

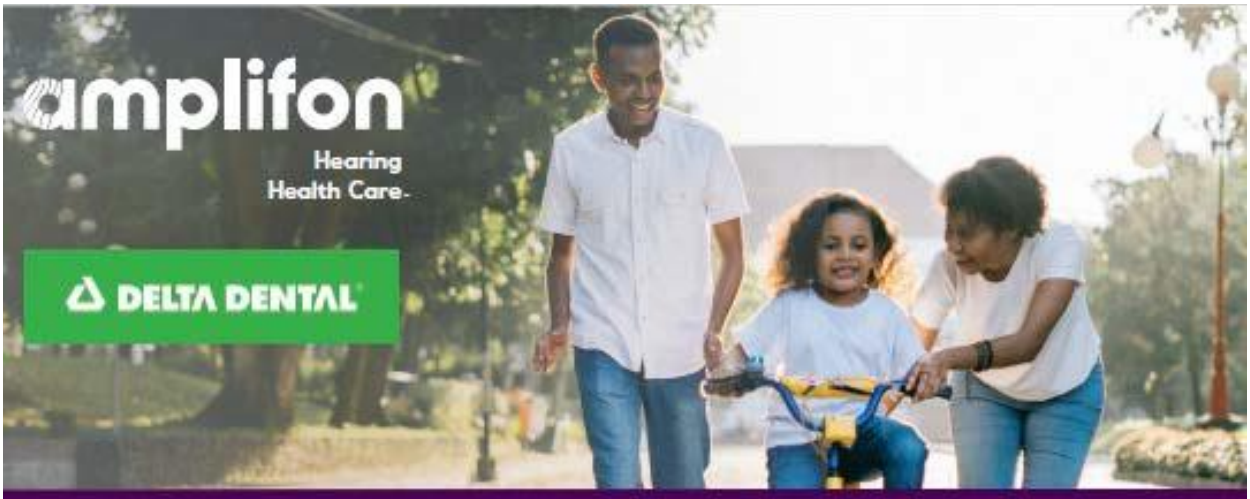
866-246-9041

When scheduling an appointment, inform the provider that you have a vision discount plan through the **EyeMed Access** panel of providers, with Delta Dental of Wisconsin.

At the time of your appointment, remind the provider that you have a vision discount plan through the **EyeMed Access Plan**.

Providers: This is NOT insurance - it is a vision discount plan.

Delta Dental is a Registered Mark of Delta Dental Plans Association.



YOUR HEARING HEALTH CARE PROGRAM FOR LIFE

Delta Dental of Wisconsin

CUSTOM HEARING SOLUTIONS

We find the solution that best fits your lifestyle and your budget from one of our 10 brands.

RISK-FREE 60-DAY TRIAL

100% money-back guarantee if not completely satisfied. No restocking or return fees.

CONTINUOUS CARE

1-year free follow-up care, 2 years free batteries, and a 3-year warranty.*

HEARING AID LOW-PRICE GUARANTEE**

If you find the same product at a lower price, bring us the local quote and we'll not only match it, we'll beat it by 5%.

ACCESSING YOUR DISCOUNT

IS AS EASY AS...

1. Call Amplifon at1-888-901-0132 and we'll find a provider near you
2. We'll explain the Amplifon process and help you schedule an appointment
3. We'll send information to you and the provider, ensuring your discount is activated

www.amplifonusa.com/deltadentalWI

ADDITIONAL MONEY-SAVING OFFER!*

CALL TODAY:1-888-901-0132

*Savings on top of our already discounted pricing. Please bring this offer with you to your appointment.

$50 off one hearing aid

OR

$125 off two hearing aids

Amplifon offers a price match on most hearing devices. Some exclusions apply. Not available where prohibited by law. Visit amplifonusa.com or call for more details.

*Some exclusions apply. Limited to one-time claim for loss and damage. Deductibles may apply.

**Amplifon offers a price match on most hearing devices. Some exclusions apply. Not available where prohibited by law. Visit amplifonusa.com or call for more details.

Hearing services are administered by Amplifon Hearing Health Care, Corp. Amplifon Hearing Health Care is solely responsible for the administration of hearing health care services, and its own financial and contractual obligations. Delta Dental of Wisconsin and Amplifon are independent, unaffiliated companies.

NOW AVAILABLE AT ALL BELLIN HEALTH PRIMARY CARE LOCATIONS

IN-PERSON AND VIDEO VISITS

NEARSITE PRIMARY CARE

Available to WCA Group Health Trust participants from Beecher Dunbar Pembine, Bonduel, Bowler, CESA 8, Crivitz, Florence County, Gillett, Goodman Armstrong Creek, Lena, Marinette, Niagara, Peshtigo, Suring, and Wausaukee School Districts; City of Marinette; and Oconto County.

- Patients are required to wear a face mask to appointments.
- To assure everyone's safety, please allow 30-minutes for appointments.

NO CHARGE* confidential appointments for covered members and dependents on the District's health plan:

- Respiratory symptoms (i.e. fever, sore throat, cough)
- COVID-19 vaccines
- Physicals for both sports and well-exams
- Chronic disease management
- Acute symptoms (i.e. ear infections, headache, migraine, urinary tract and yeast infection, burns; X-rays not included)
- Minor treatments (i.e. wart treatment, staple removal)
- Immunizations and laboratory services
- Electronic medication prescriptions and refills

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*Services not listed will be billed to personal insurance and incur normal charges.

YOU DO **NOT** NEED TO BE A BELLIN PATIENT

LOCATIONS:

- Algoma
- Ashwaubenon
- Ashwaubenon Internal Medicine and Pediatrics
- Bellevue
- Bonduel
- Brillion
- Crivitz
- Daggett
- Denmark
- De Pere East
- De Pere West
- Escanaba
- Green Bay
- Howard
- Iron Mountain
- Kewaunee
- Lakewood
- Luxemburg
- Manitowoc
- Marinette
- Marinette Employer Clinic
- Menominee
- Oconto
- Oconto Falls
- Peshtigo
- Pulaski
- Seymour
- Sturgeon Bay
- Suring
- Wrightstown

24/7 SCHEDULING:
bellin.org/wcanorth
800.528.7883

SCAN ME

bellin.org/**wcanorth**

10/11/22

REQUIRED FEDERAL NOTICES FOR 2024

HIPAA 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 towards your or your dependents' other coverage). However, you must request enrollment within insert “30 days” or any longer period that applies under the plan after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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 insert “30 days” or any longer period that applies under the plan after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact insert the name, title, telephone number and any additional contact information of the appropriate plan representative.

HIPAA NOTICE OF PRIVACY PRACTICES

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.

Effective Date of Notice: [DATE]

Who will follow this notice:

This notice describes the health information practices of [PLAN NAME] (the "Plan") and that of any third party that receives medical information from or for us to assist us in providing your [TYPE OF COVERAGE, E.G. MEDICAL, DENTAL, ETC] benefits.

Our pledge to you:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you.

This notice is required by the Standards for Privacy of Individually Identifiable Health Information regulations (the "Rule"). This notice will tell you about the ways in which we may use or disclose medical information about you. It also describes our obligations and your rights regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

HOW THE PLAN MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

The following categories describe different ways that we use and disclose medical information, as permitted by law. The Plan, its business associates, and their agents/subcontractors, if any, will use or disclose medical information to carry out treatment, payment and health care operations or other purposes permitted or required by law.

In addition, the Plan may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. The Plan will disclose your medical information to [EMPLOYER] ("Plan Sponsor") for purposes related to treatment, payment and health care operations. The plan sponsor has amended its plan documents to protect your medical information as required by the Rule.

Treatment means the provision, coordination, or management of health care by one or more health care providers, or a health care provider and a third party.

HIPAA NOTICE OF PRIVACY PRACTICES (continued)

Payment means activities undertaken by a health plan to determine coverage responsibilities and payment obligations for the provision of health care, or activities undertaken by a health care provider, or a health plan to obtain or provide reimbursement for health care.

For example, the Plan may disclose to your provider that you are eligible for benefits.

Health Care Operations means activities directly related to the provision of health care or the processing of health information. This includes internal quality oversight review, credentialing and health care provider evaluation, underwriting, insurance rating and other activities related to creation, renewal or replacement of a contract of health insurance or health benefits.

For example, the Plan may use medical information about you to project future benefit costs.

The Plan will disclose medical information about you when required by federal, state or local law.

The Plan may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

The Plan may disclose medial information if you are a member of the armed forces and this is required by military command authorities.

The Plan may disclose medical information about you for workers' compensation or similar programs.

The Plan may disclose medical information about you for public health activities. These activities may include the following:

- to prevent or control disease, injury or disability;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

The Plan may disclose medical information to a health oversight agency for activities authorized by law.

The Plan may disclose medical information about you if you are involved in a lawsuit or a dispute and we are responding to a court or administrative order. Also, the Plan may disclose medical information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

The Plan may disclose medical information about you if asked to do so by law enforcement official, such as in response to a court order, subpoena, warrant, summons or similar process;

The Plan may disclose medical information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure to funeral directors, as necessary to carry out their duties, is permitted.

HIPAA NOTICE OF PRIVACY PRACTICES (continued)

The Plan may not disclose psychotherapy notes (under most circumstances), may not disclose protected health information for marketing purposes, and may not make disclosures that constitute a sale of protected health information unless authorized by the individual. Other disclosures not mentioned in this notice also require authorization from the individual.

The Plan may not disclose protected health information that is genetic information under the Genetic Information Nondiscrimination Act ("GINA") for underwriting purposes.

YOUR RIGHTS

You have the following rights regarding medical information the Plan maintains about you:

You have the right to request an inspection and a copy of your medical information contained in a "designated record set," for as long as the Plan maintains your medical information in the designated record set.

"Designated record set," means a group of records maintained by or for a health plan that is enrollment, payment, claims adjudication and care or medical management record systems maintained by or for a health plan; or used in whole or in part by or for the health plan to make decisions about individuals. Information used for quality control or for health care operations and not used to make decisions about individuals is not in the designated record set.

The Plan has the right to charge a reasonable, cost-based fee for providing a copy of your medical information or summary or explanation of your medical information.

The Plan has the right to deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

If you feel the medical information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. You have a right to request an amendment for as long as the information is kept by the Plan.

To request an amendment, your request must be in writing and should be addressed to the following individual: [NAME OR TITLE AND CONTACT INFO OF PRIVACY OFFICIAL]. All requests for amendment of your medical information must include a reason to support the requested amendment.

The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny your request if you ask to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information which you would be permitted to inspect and copy.

HIPAA NOTICE OF PRIVACY PRACTICES (continued)

You have the right to request an "accounting of disclosures," where such disclosure was made for any purpose other than treatment, payment or health care operations. Additionally, no accounting of disclosures will be made for the following reasons:

- if the disclosure was made to the individual about his or her own medical information;
- if the disclosure was made pursuant to an authorization;
- if the disclosure was made to certain person involved in your care or payment for your care;
- if the disclosure was made prior to the compliance date of [EITHER April 14, 2003 (LARGE PLAN) OR April 14, 2004 (SMALL PLAN)].

To request an accounting of disclosures, address your request to the following individual: [NAME OR TITLE AND CONTACT INFO OF PRIVACY OFFICIAL].

If you request more than one accounting in a 12-month period, the Plan can charge a reasonable, cost-based fee for each subsequent accounting, unless you withdraw or modify the request for a subsequent accounting to avoid or reduce the fee.

You have the right to request a restriction or limitation on the medical information the Plan uses or discloses about you for treatment, payment or health care operations. You have the right to request a limit on the medical information the Plan discloses about you to someone who is involved in your care or payment for your care, such as friends or family members.

The Plan is not required to agree with your request.

You have the right to restrict certain disclosures of protected health information to a health plan where you pay out of pocket in full for the health care item or service.

To request restrictions, you must make your request in writing to the following individual: [NAME OR TITLE AND CONTACT INFO OF PRIVACY OFFICIAL]. The request must include (a) what information you want to limit, (b) whether you want to limit the Plan's use, disclosure or both, and (c) to whom you want the limits to apply.

You have the right to request to receive communications of your medical information from the Plan by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information could endanger you. The Plan will accommodate all such reasonable requests.

You will be required to request confidential communications of your medical information in writing. The request should be addressed to the following individual: [NAME OR TITLE AND CONTACT INFO OF PRIVACY OFFICIAL].

You have the right to a paper copy of this notice. You may ask the Plan to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

[USE THIS ONLY IF THE NOTICE WILL BE KEPT ON AN INTERNET OR INTRANET SITE] You may obtain a copy of this notice at the Plan's website [WEB/INTRANET ADDRESS].

HIPAA NOTICE OF PRIVACY PRACTICES (continued)

To obtain a paper copy of this notice, contact the following individual: [NAME OR TITLE AND CONTACT INFO OF PRIVACY OFFICIAL].

You have the right to be notified following a breach of unsecured protected health information.

If you believe your privacy rights have been violated, you may complain to the Plan. Any complaint must be in writing and addressed to the following individual: [NAME OR TITLE AND CONTACT INFO OF PRIVACY OFFICIAL].

You may also file a complaint with the Secretary of Health and Human Services.

The Plan will not retaliate against you for filing a complaint. The Plan will only release the minimum amount of PHI necessary to complete the required task or request.

Other uses or disclosures of your medical information not covered by this notice or the laws that apply will be made only with your written authorization, subject to your right to revoke such authorization. You may revoke the authorization at any time, providing the revocation is done in writing. You understand that the Plan is unable to take back any disclosures already made with your permission.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) ENROLLMENT NOTICE

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Please see your Summary of Benefits and Coverage (SBC) for deductible and coinsurance information.

If you would like more information on WHCRA benefits, call your Plan Administrator phone number

MODEL INDIVIDUAL **CREDITABLE** COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011

OMB 0938-0990

MEDICARE PART D: CREDITABLE COVERAGE NOTICE

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

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

MEDICARE PART D: CREDITABLE COVERAGE NOTICE (continued)

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 Name of Entity coverage [will or will not] be affected. [The entity providing the Disclosure Notice should insert an explanation of the prescription drug coverage plan provisions/options under the particular entity's plan that Medicare eligible individuals have available to them when they become eligible for Medicare Part D (e.g., they can keep this coverage if they elect part D and this plan will coordinate with Part D coverage; for those individuals who elect Part D coverage, coverage under the entity's plan will end for the individual and all covered dependents, etc.). *See* pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage) which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.]

If you do decide to join a Medicare drug plan and drop your current Name of Entity coverage, be aware that you and your dependents may be able to get this coverage back if you experience a qualifying event or at the next open enrollment period.

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 Name of Entity 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 (Or call Alternative Contact at (XXX) XXX-XXXX. **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 Name of Entity changes. You also may request a copy of this notice at any time.

MEDICARE PART D: CREDITABLE COVERAGE NOTICE (continued)

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).

Note: delete red text if not including Optional Insert - Entities can choose to insert the following information box if they choose to provide a personalized disclosure notice.
Medicare Eligible Individual's Name: [Full Name of Medicare Eligible Individual]
Individual's DOB or unique Member ID: [Individual's Date of Birth], or [Member ID]

The individual stated above has been covered under creditable prescription drug coverage for the following date ranges that occurred after May 15, 2006:

From: [MM/DD/YY]	**To:** [MM/DD/YY]
From: [MM/DD/YY]	**To:** [MM/DD/YY]

Date: [MM/DD/YY]

Name of Entity/Sender:	[Name of Entity]
Contact--Position/Office:	[Position/Office]
Address:	[Street Address, City, State & Zip Code of Entity]
Phone Number:	[Entity Phone Number]

MODEL INDIVIDUAL **NON-CREDITABLE** COVERAGE DISCLOSURE NOTICE LANGUAGE OMB 0938-0990
FOR USE ON OR AFTER APRIL 1, 2011

MEDICARE PART D: NON-CREDITABLE COVERAGE NOTICE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Name of Entity 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.
There are three 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. Name of Entity has determined that the prescription drug coverage offered by the Name of Plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the [Insert Name of Plan]. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can keep your current coverage from Name of Plan However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

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

MEDICARE PART D: NON-CREDITABLE COVERAGE NOTICE (continued)

[INSERT IF EMPLOYER/UNION SPONSORED GROUP PLAN: However, if you decide to drop your current coverage with [Insert Name of Entity], since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under [Insert Name of Plan.]

[INSERT IF PREVIOUS COVERAGE PROVIDED BY THE ENTITY WAS CREDITABLE COVERAGE: Since you are losing creditable prescription drug coverage under the [Insert Name of Plan], you are also eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.]

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

Since the coverage under Name of Plan is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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 Name of Entity coverage will or will not be affected. [The entity providing the Disclosure Notice should insert an explanation of the prescription drug coverage plan provisions/options under the particular entity's plan that Medicare eligible individuals have available to them when they become eligible for Medicare Part D (e.g., they can keep this coverage if they elect part D and this plan will coordinate with Part D coverage; for those individuals who elect Part D coverage, coverage under the entity's plan will end for the individual and all covered dependents, etc.). [*See* pages 9 - 11 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.]

If you do decide to join a Medicare drug plan and drop your current Insert Name of Entity coverage, be aware that you and your dependents may be able to get this coverage back if you experience a qualifying event or at the next open enrollment period.

MODEL INDIVIDUAL **NON-CREDITABLE** COVERAGE DISCLOSURE NOTICE LANGUAGE OMB 0938-0990
FOR USE ON OR AFTER APRIL 1, 2011

MEDICARE PART D: NON-CREDITABLE COVERAGE NOTICE (continued)

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE…

Contact the person listed below for further information. or call Alternative Contact at [(XXX) XXX-XXXX]. 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 Name of Entity 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).

Note: delete red text if not including Optional Insert - If a beneficiary has had creditable coverage under the entities plan for any period of time since May 15, 2006, entities can insert the following information box if they choose to provide a personalized disclosure notice.

Medicare Eligible Individual's Name: [Full Name of Medicare Eligible Individual] Individual's DOB or unique Member ID: [Individual's Date of Birth], or [Member ID]

The individual stated above has been covered under **creditable** prescription drug coverage for the following date ranges that occurred after May 15, 2006:

From: [MM/DD/YY] **To:** [MM/DD/YY]
From: [MM/DD/YY] **To:** [MM/DD/YY]

Date: [MM/DD/YY]
Name of Entity/Sender: [Name of Entity]
Contact--Position/Office: [Position/Office]
Address: [Street Address, City, State & Zip Code of Entity]
Phone Number: [Entity Phone Number]

MARKETPLACE COVERAGE NOTICE

GENERAL INFORMATION

When key parts of the health care law took effect, you were eligible for a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you look at options for you and your family, this notice provides some basic information about the new Marketplace and the employment based coverage offered to you.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find private 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. Annual open enrollment for private health insurance coverage through the Marketplace runs during the months of November, December, January and February. The specific timeline will be announced each year.

CAN I SAVE MONEY ON MY HEALTH INSURNACE 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 are eligible for depends on your household income.

DOES THE HEALTH INSURANCE WE OFFER TO YOU AFFECT YOUR ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If we have offered health coverage that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in our 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 self-only coverage under our health plan is more than a certain percentage of your household income for the year, or if our health plan does not meet the "minimum value"[1] standard set by the Affordable Care Act, you may be eligible for a tax credit. Please visit healthcare.gov for the annual affordability percentage or contact the employer identified on the following page of this notice.

Note: If you purchase a health plan through the Marketplace instead of accepting our health plan coverage, then you may lose our contribution (if any) to your coverage under our health plan. Also, our contribution – as well as your employee contribution – 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 ABOUT THE MARKETPLACE?

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the marketplace and its cost. You can 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.

1
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.

MARKETPLACE COVERAGE NOTICE (continued)

INFORMATION ABOUT THE HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

If you complete an application for coverage through the Marketplace, you will be asked for information about our health plan. The information below will help you complete an application for coverage in the Marketplace.

Employer Name
Employer Identification Number (EIN):
Employer Address:
Employer Phone Number:
Who can we contact about employee health coverage at this job? Phone Number (if different from above):

- You may also be asked whether or not you are currently eligible for our health plan or whether you will become eligible within the next three months. In addition, if you are or will become eligible, you may be required to list the names of your dependents that are eligible for coverage under our health plan.

- If you would like information about the eligibility requirements for our health plan, please read the eligibility provisions described in the Summary Plan Description for our health plan. You can obtain a copy of the Summary Plan Description by contacting your Employer at the phone and/or email listed above.

- If you are eligible for coverage under our health plan, you may be required to check a box indicating whether or not our health plan meets the minimum value standard. Our health plan coverage meets the minimum value standard.

- If you are eligible for coverage under our health plan, you may be asked to provide the amount of premiums you must pay for self-only coverage under the lowest-cost health plan that meets the minimum value standard. If you had the opportunity to receive a premium discount for any tobacco cessation program, you must enter the premium you would pay if you received the maximum discount possible for a tobacco cessation program.

- If you would like information about the premiums for self-only coverage under our lowest-cost health plan, please contact your Employer at the phone and/or email listed above.

- You may also be asked whether or not we will be making certain changes to our health plan coverage for the new plan year. As usual, we will notify you about changes to our health plan coverage after we approve any such changes and inform employees about those changes at the appropriate time. If you are not sure how to answer this question on your Marketplace application, please contact the Marketplace.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

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

ALABAMA – Medicaid	**ALASKA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

CHIP (continued)

GEORGIA – Medicaid	INDIANA – 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	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

CHIP (continued)

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**

Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

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

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

WELLNESS PROGRAM DISCLOSURE

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at contact information and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.