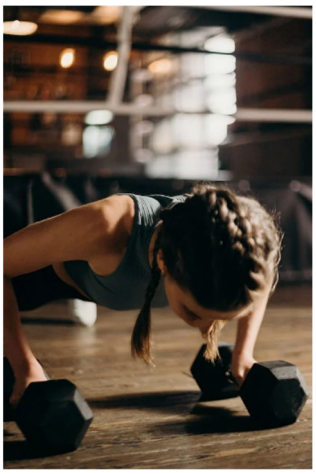
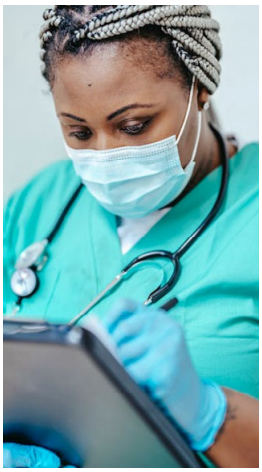
2023-2024 Benefits Guide
City of Bondurant




Bondurant
Life Connecting

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

BENEFITS OVERVIEW

Our Benefits Program Has You Covered

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

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

Benefits Available To You	
Medical	**Dental**
Vision	**Life and AD&D Insurance**
Voluntary Life and AD&D	**Short-Term Disability**
Long-Term Disability	**Flexible Spending Accounts**
IPERS	**MissionSquare Retirement**

You are eligible to enroll in City of Bondurant's benefit plans if you are a regular, full-time employee scheduled to work at least 40 hours per week. As a regular, full-time employee, you are eligible for benefits on the first day of the month following your date of hire.

DEPENDENT ELIGIBILITY

You may also cover your eligible dependents, including:

- Your legal spouse.
- Your eligible children up to age 26 for medical coverage; your unmarried, eligible children up to age 25 for dental and vision coverage.
- "Children" are defined as your natural children, stepchildren, legally adopted children, and children for whom you are the court-appointed legal guardian.
- Physically or mentally disabled children of any age who are incapable of self-support. Proof of disability may be requested.

If your child becomes ineligible for coverage (i.e., turning age 26 under the medical plan), you must notify the Human Resources Department at 515-967-2418.

WHEN COVERAGE BEGINS

Initial Enrollment

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

Annual Open Enrollment

The open enrollment period for Medical, Dental and Vision runs from May 5, 2023, through May 19, 2023. The Medical, Dental, and Vision benefits you elect during open enrollment will be effective from July 1, 2023, to June 30, 2024.

The open enrollment period for Flexible Spending Account runs from December 1, 2023, through December 31, 2023. The Flexible Spending Account benefit you elect will be effective from January 1, 2024, to December 31, 2024.

Making Changes to Coverage

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

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

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

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

Special Enrollment Rules

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

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

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

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

In addition to the changes described previously, you may enroll yourself and your spouse (with or without the new dependent) in a City of Bondurant health plan following marriage or adoption, placement for adoption, or birth of a child, as long as you request enrollment within 31 days of the event. You must be enrolled to cover your dependents. If you have a special enrollment event and want to enroll for health coverage, call Human Resources at 515-967-2418.

CHOOSING A MEDICAL PLAN

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

When it comes to medical coverage, City of Bondurant offers you:

- POS Plan

Point of Service (POS)

The POS plans offer in-network and out-of-network benefits. When you need care, you decide whether to go to an in-network or an out-of-network provider. If you receive care from in-network doctors and facilities, your out-of-pocket costs will be lower than if you use out-of-network providers and facilities because network providers discount their fees. And, with in-network providers, you generally do not have to file claims.

If you choose to receive care from an out-of-network provider, the medical plan pays a lower benefit, and you must file a claim to receive reimbursement for covered expenses.

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

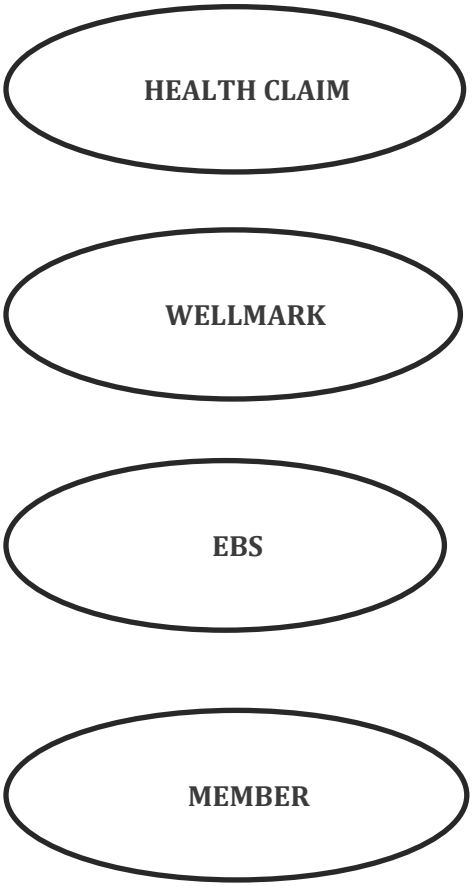
MEDICAL PLAN COMPARISON

	POS Plan	
	In-Network	**Out-of-Network**
Annual Deductible		
Individual	$5,000 (PSF to $500)	
Family	$10,000 (PSF to $1,000)	
Out of Pocket Maximums		
Individual	$7,350 (PSF to $1,000)	
Family	$14,700 (PSF to $2,000)	
Lifetime Maximum	Unlimited	
	You Pay	
Coinsurance/Copays		
Preventive Care	Covered at 100%	Deductible, 40% Coinsurance
Primary Care Physician	$10 Copayment	Deductible, 40% Coinsurance
Specialist	$10 Copayment	Deductible, 40% Coinsurance
Diagnostics, X-Ray, and Lab Services	Deductible, 30% Coinsurance	Deductible, 40% Coinsurance
Urgent Care	$10 Copayment	Deductible, 40% Coinsurance
Emergency Room	Deductible, 30% Coinsurance	
Inpatient Hospital Care	Deductible, 30% Coinsurance	Deductible, 40% Coinsurance
Outpatient Surgery	Deductible, 30% Coinsurance	Deductible, 40% Coinsurance
Retail Prescription Drug Coverage	$10 Tier 1/ $25 Tier 2/ $40 Tier 3/ $40 Tier 4/ $85 Specialty	
Medical Rates	**Monthly Rates**	
Employee	$0.00	
Employee/Spouse	$115.97	
Employee/Child(ren)	$136.82	
Family	$182.43	

Partial Self-Funded Illustration

City of Bondurant's health insurance plans have two components: the Wellmark medical plan and the self-funded plan. The Wellmark's deductible and out-of-pockets maximums are paid partially by the City, and partially by you. This process is referred to as Partial Self-Funding (PSF) and is administered through Employee Benefit Systems (EBS).

City of Bondurant offers their employee's a PSF plan to be able to provide them rich benefit plan options at a more affordable cost. The only time you will be impacted is if you, or a covered dependent, have a medical situation that reaches the PSF deductible and out-of-pocket maximum limit.



1. **You incur medical services.**
   Your medical provider will file your claim with Wellmark using the information from your ID card.

2. **Wellmark settles your claim.**
   All claims are settled under your higher deductible plan at Wellmark. If applicable, Wellmark will make a payment to your provider, and you will receive an Explanation of Benefits (EOB).

3. **EBS Settles Your Claim**
   EBS receives the EOB from Wellmark to process the claim on your lower deductible plan. If applicable, EBS will make a payment to your provider. Your EBS EOB will be mailed to your home, or you may register for paperless EOB's on the Gateway Portal.

4. **Member Receives EOB**
   EBS recommends members wait to make payments to their provider until the EBS EOB has been received. Member is responsible for Deductible, Coinsurance, Copay and Out of Pocket Maximum on PSF plan.

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

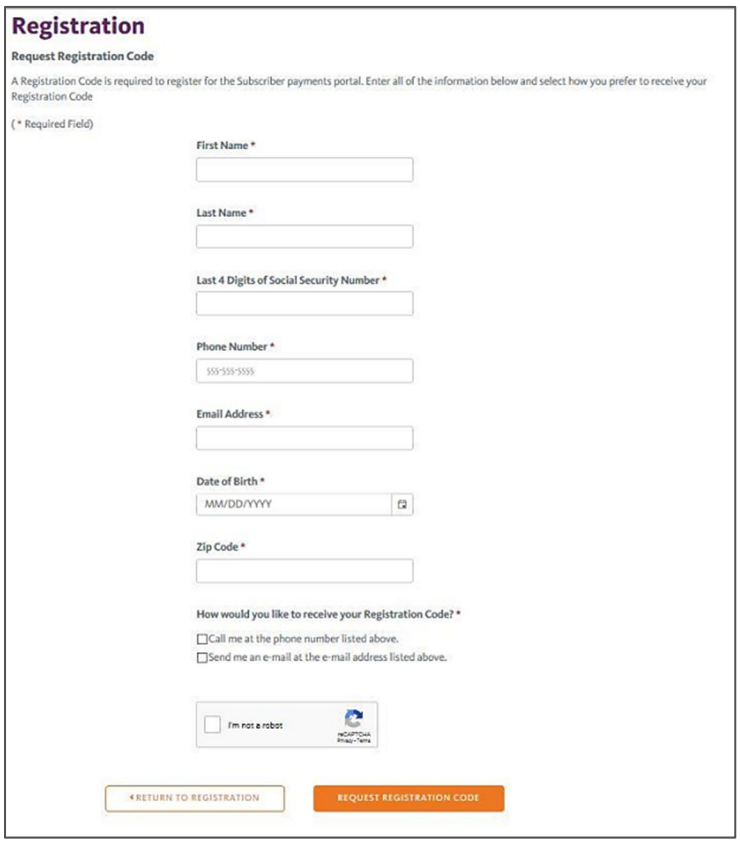
Why should I enroll in Zelis Payments direct deposit?

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

It is easy to enroll:

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

1 - Request your registration code:



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

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

Click "Request Registration Code".

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

2 - Enter your registration code:

Enter your registration code and your email address.

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

3 - Create a password:

- Once you've clicked "Register" you will receive an automated email with a link to create your password.
- After adding your password, you will be redirected to a log in screen. From here you can access your new account.

4 - After logging in, select Zelis ACH:

- Your user account is now active! Make sure to select Zelis ACH to complete adding direct deposit.
- Once you've completed your bank setup, Zelis will initiate a pre-note test on the account provided for additional security verification. A small deposit will be made in a random amount no larger than $1.00.
- Review your bank statement for the deposit and log-in to the Zelis portal to enter the exact amount for final confirmation.

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

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

DENTAL PLAN

City of Bondurant's Dental Plan is administered through Delta Dental and provides you and your family with coverage for typical dental expenses, such as cleanings, X-rays, and fillings for children.

Dental Premier Network

Delta Dental Premier is Delta's original fee-for-service plan that offers the largest network of dentists. These dentists have agreed to contracted fees with Delta Dental, so for covered services, you pay no more than your copay and deductible. You can view if your provider is in the Premier Network at www.deltadentalia.com.

Non-Participating Network

The Non-Participating Network, also known as Out of Network, is the group of Dentist who have not agreed to participate in Delta Dental's Network. If your dentist falls within this network, you will pay more for your dental services than you would if your dentist was in the Premier Network. There are less discounts available to you in the Non-Participating Network.

Dental Plan Highlights

Plan Feature	Premier Dentist	Non-Participating Dentist
Annual Deductible Per Person	$25	$50
Annual Benefit Maximum	$2,000	
Preventive Services (check-ups, teeth cleaning, x-rays, maintenance therapy)	0%	20%
Basic Services (cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery)	20%	40%
Major Services (Posterior composites, endodontic, periodontal, crowns, inlays, onlays, post, cores, bridges, dentures) Implants	50% 60%	60% 70%
Orthodontia	50%	
Orthodontia Lifetime Maximum	$1,500	
Dental Premiums	**Employee Monthly Cost**	
Employee	$0.00	
Dependents (Age 21+)	$8.21	
Dependents (Under age 21)	$6.43	

VISION PLAN

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

Vision Coverage

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

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

Vision Plan Highlights

	In-Network	Out-of-Network
Plan Feature	**You Pay**	**Reimbursement**
Exam	$10 Copayment	Up to $35
Prescription Glasses		
Single Lenses	$10 Copayment	Up to $25
Bifocals – Lined	$10 Copayment	Up to $40
Trifocals – Lined	$10 Copayment	Up to $55
Frames	80% of Balance over $125	Up to $75
Contacts		
Medically Necessary	Covered at 100%	Up to $200
Elective – In Lieu of Glasses	85% of Balance over $150	Up to $120
Standard Contact Lens Exam (Fitting and Evaluation)	Up to $40	N/A
Benefit Frequency		
Exam	Once every calendar year	
Frames	Once every 2 calendar years	
Lenses	Once every calendar year	
Contacts	Once every calendar year	
Vision Rates	**Employee Monthly Cost**	
Employee	$0.00	
Employee/Spouse	$1.10	
Employee/Child(ren)	$1.41	
Family	$2.26	

LIFE INSURANCE

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

Basic Life and AD&D Insurance

City of Bondurant automatically provides Basic Life Insurance for all eligible employees at no cost. Basic Life and AD&D Insurance benefit of $50,000. The benefit is paid to your beneficiaries in the event of your death.

This chart provides you a brief summary of the key benefits of the life coverage available from Principal Life Insurance Company. Following the chart, you will find additional information to answer questions you may have. For a complete list of all your life coverage benefits and restrictions, please refer to your booklet or contact your employer.

Plan Overview	
Benefit Amount	$50,000
Guaranteed Issue	Under age 70: $50,000 Over age 70: The lesser of $18,000 or the amount with prior carrier
Benefit Reduction	Age 65: 25% Age 70: An additional 25%
AD&D Benefit	100%-Loss of life, both hands or feet or one hand and one foot, or loss of eyesight 50%-Loss of one hand, or one foot, or sight in one eye 25%-Loss of thumb and index finger on same hand

IRS Rules about Basic Life Coverage

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

Optional Life and AD&D Insurance

In addition to Basic Life Insurance, you may also purchase Optional Life Insurance for yourself, your spouse, and your dependent children. However, you may only elect coverage for your dependents if you enroll for Optional Life coverage for yourself. You pay for the cost of Optional Life Insurance on an after-tax basis through payroll deductions.

Optional Life and AD&D Insurance Coverage

Plan Overview	
Benefit Maximum	$300,000
Benefit Minimum	$10,000
Guaranteed Issue	Under age 70: $70,000 Over age 70: $10,000
Benefit Reduction	Age 65: 25% Age 70: An additional 25%
Spouse Benefit Amounts	Maximum: $100,000 Minimum: $5,000 Guarantee Issue: • Under age 70: $20,000 • Over age 70: $10,000
Child(ren) Benefit Amounts	$5,000-$25,000 in $5,000 increments

Beneficiary Designation

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

DISABILITY COVERAGE

City of Bondurant offers you two disability plans that work together to keep all or part of your paycheck coming if you cannot work because of illness, injury, or pregnancy. Disability benefits are administered through Principal.

Short-Term Disability

Short-Term Disability (STD) benefits are provided by City of Bondurant to all eligible employees at no cost. Below is a summary of your Short-Term Disability plan:

Plan Overview	
Primary Weekly Benefit	60% of earnings up to $100
Benefit Amount	Primary weekly benefit minus other income sources
Elimination Period	Accidents: 1st Day Sickness: 8th Day
Benefit Duration	Up to 13 weeks

Long-Term Disability

Long-Term Disability (LTD) benefits are provided by City of Bondurant to all eligible employees at no cost. Below is a summary of your Long-Term Disability plan:

Plan Overview	
Primary Monthly Benefit	60% of your salary up to $6,000 per month. If your salary exceeds $10,00 per month, your benefit will be capped at $6,000 per month
Benefit Amount	Primary weekly benefit minus other income sources
Elimination Period	90 Days
Own Occupation Period	2 years
Benefit Duration	SSNRA
Pre-Existing Limitations	3 months prior/12 months insured
Survivor Benefit	3 times of primary monthly benefit

When Are You Disabled?

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

- Your doctor must certify that you are not able to do your job at City of Bondurant.

FLEXIBLE SPENDING ACCOUNTS

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

How the FSAs Work

City of Bondurant offers two types of FSAs:

- Health Care FSA
- Dependent Care FSA

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

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

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

HEALTH CARE FSA

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

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

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

Annual Contribution Amount

You can contribute $0 to $3,050 per year to the Health Care FSA.

Over-the-Counter Medications

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

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

How the Debit Card Works

If you enroll in the Health Care FSA, you will receive one debit card in the mail. To request additional debit cards for your family members, please contact i-Solved.

You can use your debit card at certain places to pay for eligible expenses up-front, such as prescription drugs and office visit copays, without having to pay with cash and wait for a reimbursement. If you use your debit card at a health care provider's office or at a vendor that has the software in place to track eligible FSA expenses, you will not be required to submit a receipt. For a list of vendors that have this software, go to www.isolvedbenefitservices.com.

However, for most debit card transactions, you will need to submit your receipts as substantiation of your expense, so it's important to keep them.

If you choose not to use your debit card, you can always pay for your eligible expense and file a claim for reimbursement.

Dependent Care FSA

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

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

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

Eligible Dependent Care Expenses

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

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

Some typical expenses that are eligible for reimbursement under the plan are:
Licensed nursery school and day care centers for children
Licensed day care centers for disabled dependents
Services from a care provider over the age of 19 (inside or outside the home)
Day camps
After-school care

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

Annual Contribution Amount

You can contribute $100 to $5,000 per year to the Dependent Care FSA. If you are married and you and your spouse file separate tax returns, the maximum you can contribute is $2,500 each.

Important FSA Considerations

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

OTHER BENEFITS

IPERS

IPERS is the state's largest public retirement system. We are committed to transparent communication with our members, lawmakers and all Iowans.

The Iowa Legislature created IPERS in 1953 to attract and retain quality public employees, including those who teach our children, maintain our roads and parks, care for our most vulnerable residents, and protect our citizens. Today, IPERS' Trust Fund continues to hover around $40 billion and pays more than $2.5 billion in annual benefits.

- 1 in 10 Iowans is an IPERS member.
- IPERS represents more than 392,725 members.
- Retirees living in Iowa receive the greatest share of IPERS' annual benefit payments, $2.2 billion, collectively. Residents reinvest this money in their communities and grow the local and state economies.

For more information about IPERS and how to enroll visit: **https://ipers.org/members**

MissionSquare

MissionSquare Retirement is a non-profit independent financial services corporation providing retirement plans and related services for more than a million public sector participant accounts. Their mission is to help build retirement security for public employees.

They provide tools to help you save, invest, and retire on time. For more information go to: **www.icmarc.org**

IMPORTANT CONTACTS

Resource	Phone Number	Website/E-mail
Medical and Prescription	800-524-9242	www.wellmark.com
Dental	800-544-0718	www.deltadentalia.com
Vision	800-544-0718	www.deltadentalia.com
Flexible Spending Accounts	800-300-9691	www.isolvedbenefitservices.com
Life Insurance	800-245-1522	www.principal.com
Disability Coverage	800-245-1522	www.principal.com
IPERS	800-622-3849	https://ipers.org/members
MissionSquare	202-759-7130	www.icmarc.org
Holmes Murphy Contact: Becca Corbett	515-381-7449	Bcorbett@holmesmurphy.com

City of Bondurant's
Annual Notices
Chip Notice
SBC

CHIP NOTICE

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

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

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

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

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

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

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

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

State	Website/E-mail	Phone
Georgia (Medicaid)	*HIPP:* **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp** *CHIPRA:* **https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra**	678-564-1162, press 1 678-564-1162, press 2
Indiana (Medicaid)	*Healthy Indiana Plan for low-income adults 19-64:* **http://www.in.gov/fssa/hip/** *All other Medicaid:* **https://www.in.gov/medicaid**	1-877-438-4479 1-800-457-4584
Iowa (Medicaid and CHIP)	*Medicaid:* **https://dhs.iowa.gov/ime/members** *CHIP:* **http://dhs.iowa.gov/Hawki** *HIPP:* **https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp**	1-800-338-8366 1-800-257-8563 1-888-346-9562
Kansas (Medicaid)	**https://www.kancare.ks.gov/**	1-800-792-4884
Kentucky (Medicaid and CHIP)	*Medicaid:* **https://chfs.ky.gov** *KI-HIPP:* **https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.apsx** *KI-HIPP E-mail:* **KIHIPP.PROGRAM@ky.gov** *KCHIP:* **https://kidshealth.ky.gov/Pages/index.aspx**	 1-855-459-6328 1-877-524-4718
Louisiana (Medicaid)	**www.medicaid.la.gov** **www.ldh.la.gov/lahipp**	1-888-342-6207 1-855-618-5488
Maine (Medicaid)	**https://www.maine.gov/dhhs/ofi/applications-forms** **https://www.mymaineconnection.gov/benefits/s/?language=e n_US**	*Enroll:* 1-800-442-6003 *Private HIP:* 1-800-977-6740 TTY: Maine relay 711
Massachusetts (Medicaid and CHIP)	**https://www.mass.gov/masshealth/pa**	1-800-862-4840 TTY: 617-886-8102
Minnesota (Medicaid)	**https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp**	1-800-657-3739
Missouri (Medicaid)	**http://www.dss.mo.gov/mhd/participants/pages/hipp.htm**	573-751-2005
Montana (Medicaid)	**http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP** **HHSHIPPProgram@mt.gov**	1-800-694-3084
Nebraska (Medicaid)	**http://www.ACCESSNebraska.ne.gov**	1-855-632-7633 *Lincoln:* 402-473-7000 *Omaha:* 402-595-1178
Nevada (Medicaid)	**http://dhcfp.nv.gov/**	1-800-992-0900
New Hampshire (Medicaid)	**https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program**	603-271-5218 or 1-800-852-3345, ext. 5218
New Jersey (Medicaid and CHIP)	*Medicaid:* **http://www.state.nj.us/humanservices/dmahs/clients/medicaid/** *CHIP:* **http://www.njfamilycare.org/index.html**	*Medicaid:* 609-631-2392 *CHIP:* 1-800-701-0710
New York (Medicaid)	**https://www.health.ny.gov/health_care/medicaid/**	1-800-541-2831
North Carolina (Medicaid)	**https://medicaid.ncdhhs.gov/**	919-855-4100
North Dakota (Medicaid)	**http://www.nd.gov/dhs/services/medicalserv/medicaid/**	1-844-854-4825
Oklahoma (Medicaid and CHIP)	**http://www.insureoklahoma.org**	1-888-365-3742
Oregon (Medicaid)	**http://healthcare.oregon.gov/Pages/index.aspx** **http://www.oregonhealthcare.gov/index-es.html**	1-800-699-9075
Pennsylvania (Medicaid and CHIP)	Medicaid: **https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx** *CHIP:* **Children's Health Insurance Program (CHIP) (pa.gov)**	*Medicaid:* 1-800-692-7462 *CHIP:* 1-800-986-KIDS (5437)
Rhode Island (Medicaid and CHIP)	**http://www.eohhs.ri.gov/**	1-855-697-4347 or 401-462-0311 (Direct RIte)
South Carolina (Medicaid)	**https://www.scdhhs.gov**	1-888-549-0820
South Dakota (Medicaid)	**http://dss.sd.gov**	1-888-828-0059
Texas (Medicaid)	**http://gethipptexas.com/**	1-800-440-0493
Utah (Medicaid and CHIP)	*Medicaid:* **https://medicaid.utah.gov/** *CHIP:* **http://health.utah.gov/chip**	1-877-543-7669
Vermont (Medicaid)	**https://dvha.vermont.gov/members/medicaid/hipp-program**	1-800-250-8427
Virginia (Medicaid and CHIP)	**https://www.coverva.org/en/famis-select** **https://www.coverva.org/en/hipp**	1-800-432-5924
Washington (Medicaid)	**https://www.hca.wa.gov/**	1-800-562-3022
West Virginia (Medicaid)	**https://dhhr.wv.gov/bms/** **http://mywvhipp.com/**	*Medicaid:* 304-558-1700 *CHIP:* 1-855-699-8447
Wisconsin (Medicaid and CHIP)	**https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm**	1-800-362-3002
Wyoming (Medicaid)	**https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/**	1-800-251-1269

IMPORTANT NOTICE FROM CITY OF BONDURANT 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 Bondurant 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 Bondurant has determined that the prescription drug coverage offered by Wellmark is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

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

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

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current City of Bondurant coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current City of Bondurant 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 Bondurant and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher

premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…
Contact the person listed below for further 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 Bondurant changes. You also may request a copy of this notice at any time.

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	07/01/2023
Name of Entity/Sender:	City of Bondurant
Contact--Position/Office:	Jene Jess: Finance & Employee Service Director
Address:	200 2nd St NE, PO Box 37 Bondurant, IA 50035
Phone Number:	515-967-2418

HIPAA SPECIAL ENROLLMENT NOTICE

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

Loss of Other Coverage (including Medicaid and State Child Health Coverage)
If you are declining coverage for yourself or your dependents (including spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). Some plans may allow longer than 30 days, so please refer to your plan documents for your specific plan details.

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

Marriage, Birth, or Adoption
If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption. Some plans may allow longer than 30 days, so please refer to your plan documents for your specific plan details.

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

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

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

WOMEN'S HEALTH & CANCER RIGHTS ACT OF 1998

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

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

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

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

NEWBORNS' AND MOTHER'S HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

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

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent (as adjusted each year after 2014) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

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

How Can I Get More Information?

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

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

PRIVACY NOTICE

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. Ask us how to do this.

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 **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

We will not retaliate against you for filing a complaint.

YOUR CHOICES

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

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

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases, we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

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

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

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/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues
We can share health information about you for certain situations such as:

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

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

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

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
We can share health information about you with organ procurement organizations.

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

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

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

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information.

We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

We must follow the duties and privacy practices described in this notice and give you a copy of it.

We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.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.

Wellmark Health Plan of Iowa

Coverage Period: 07/01/2023 – 06/30/2024
Coverage for: Single & Family | Plan Type: POS

IGHCP Plan 9 POS

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.wellmark.com or call 1-800-524-9242. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-524-9242 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$5,000** person/**$10,000** family per calendar year.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Well-child care, preventive care, in-network independent labs, in-network prosthetic limbs and services subject to health and drug card copayments are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No. There are no other deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Health: **$7,350** person/**$14,700** family per calendar year. Drug Card: **$7,350** person/**$14,700** family per calendar year. The In-Network health and drug card out-of-pocket maximum amounts accumulate together.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.wellmark.com or call 1-800-524-9242 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why this Matters:
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay per date of service	40% coinsurance	Primary Care Practitioners (PCP) are defined as General and Family Practice, Internal Medicine, OB/GYN, Pediatricians, Nurse Practitioners, Certified Nurse Midwives and PAs.
	Specialist visit	$10 copay per date of service	40% coinsurance	Applies to Non-PCP providers. Hearing exams are covered according to ACA guidelines.
	Preventive care/screening/ immunization	No charge	Not covered	One preventive exam, one gynecological exam with Pap smear, and one mammogram per calendar year. Well-child care is covered to age 7. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	40% coinsurance	For a test in a provider's office or clinic, your cost is included in the cost-share listed above.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	40% coinsurance	For a test in a provider's office or clinic, your cost is included in the cost-share listed above.

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242. You can find your Coverage Manual at sbccmfinder.wellmark.com.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.wellmark.com/prescriptions.	Tier 1	$10 copay per prescription	$10 copay per prescription	Drugs listed on Wellmark's Blue Rx Complete Drug List are covered. Drugs not on this Drug List are not covered. For out-of-network prescription drugs, you may be balance billed. 1 copay for 30-day supply. 3 copays for 90-day supply (Retail maintenance). 2 copays for 90-day supply (Mail order maintenance). Specialty drugs are covered only when obtained through the CVS Specialty Pharmacy Program. See wellmark.com/prescriptions for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your plan.
	Tier 2	$25 copay per prescription	$25 copay per prescription	
	Tier 3	$40 copay per prescription	$40 copay per prescription	
	Tier 4	$40 copay per prescription	$40 copay per prescription	
	Specialty drugs	$85 copay per prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	40% coinsurance	------None------
	Physician/surgeon fees	30% coinsurance	40% coinsurance	------None------
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	For emergency medical conditions treated out-of-network, it is likely you may not be balance billed pursuant to the federal rules developed for implementation of the No Surprises Act.
	Emergency medical transportation	30% coinsurance	30% coinsurance	For covered non-emergent situations, out-of-network ambulance services are NOT reimbursed at the in-network level. The member may be balance billed for any out-of-network service as established under the rules developed for implementation of the No Surprises Act.
	Urgent care	$10 copay per date of service for facility and physician(s) combined	40% coinsurance	------None------
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	40% coinsurance	------None------
	Physician/surgeon fees	30% coinsurance	40% coinsurance	------None------

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242. You can find your Coverage Manual at sbccmfinder.wellmark.com.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $10 copay per date of service Facility: 30% coinsurance	40% coinsurance	------None------
	Inpatient services	30% coinsurance	40% coinsurance	------None------
If you are pregnant	Office visits	30% coinsurance	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for preventive services. For any in-network services that fall outside of routine obstetric care, the office visit benefits shown above may apply.
	Childbirth/delivery professional services	30% coinsurance	40% coinsurance	Benefits shown reflect OB/GYN practitioner services which are typically globally billed at time of delivery for pre-natal, post-natal and delivery services.
	Childbirth/delivery facility services	30% coinsurance	40% coinsurance	------None------
If you need help recovering or have other special health needs	Home health care	30% coinsurance	40% coinsurance	------None------
	Rehabilitation services	Office: $10 copay per date of service Facility: 30% coinsurance	40% coinsurance	------None------
	Habilitation services	Office: $10 copay per date of service Facility: 30% coinsurance	40% coinsurance	------None------
	Skilled nursing care	30% coinsurance	40% coinsurance	------None------
	Durable medical equipment	30% coinsurance	40% coinsurance	20% coinsurance applies to in-network prosthetic limbs.
	Hospice services	30% coinsurance	40% coinsurance	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242. You can find your Coverage Manual at sbccmfinder.wellmark.com.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	------None------
	Children's glasses	Not covered	Not covered	------None------
	Children's dental check-up	Not covered	Not covered	------None------

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242. You can find your Coverage Manual at sbccmfinder.wellmark.com.

Excluded Services & Other Covered Services:

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

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

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

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

short term intermittent home skilled nursing

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, you can contact: Wellmark at 1-800-524-9242 or the Iowa Insurance Division at 515-654-6600.

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

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

About These Coverage Examples:

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

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

The plan's overall deductible	$5,000
PCP copayment	$10
Hospital(facility) coinsurance	30%
Other coinsurance	30%

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$10
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	**$60**
The total Peg would pay is	**$6,070**

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

The plan's overall deductible	$5,000
Specialist copayment	$10
Hospital(facility) coinsurance	30%
Other coinsurance	30%

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$50
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	**$20**
The total Joe would pay is	**$1,070**

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

The plan's overall deductible	$5,000
Specialist copayment	$10
Hospital(facility) coinsurance	30%
Other coinsurance	30%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$60
Coinsurance	$0
What isn't covered	
Limits or exclusions	**$0**
The total Mia would pay is	**$1,960**

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

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

Wellmark Language Assistance

Discrimination is against the law

Wellmark Blue Cross and Blue Shield complies with applicable state and federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

Wellmark provides:

- Free aids and services to people with disabilities so they may communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

You have the right to get this information and help in your language for free. If you need these services, call 800-524-9242.

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

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

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

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

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 800-524-9242 أو (خدمة الهاتف النصي: 888-781-4262).

ສ່ຽງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາ ໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ທີ. (TTY: 888-781-4262.)

주의: 한국어 를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें : अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, नि:शुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

ATTENTION : si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deitsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

တၢ်နှးသ့ဉ်ညါ–နမ့ၢ်ကတိၤကညီကျိာ်.ကျိာ်တၢ်မၤစၢၤတၢ်ဖံးတၢ်မၤတဖဉ်.လၢတဘဉ်လာ်ဘူးလဲ.ဆိဉ်လၢနဂၢ်လီၤ.ဆဲးကျိးဆူ ၈၀၀–၅၂၄–၉၂၄၂မ့တမ့ၢ်(TTY:၈၈၈–၇၈၁–၄၂၆၂)တက့ၢ်.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस्।

ማሳሰቢያ: አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ እገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም (በTTY: 888-781-4262) ይሙላው ያነጋግሩን።

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maaɗa. Heƃir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNAA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) quunnamaa.

УВАГА! Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телетайп: 888-781-4262).

Ge': Diné k'ehjí yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Kojį' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)

M-2318376 02/21 A

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-373-1327. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-524-9242 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	The employer self-funds a portion of the deductible under the major medical plan. **In-network deductible:** **$500** person/ **$1,000** family **Out-of-network deductible:** **$500** person/ **$1,000** family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. See the primary SBC of the insured group health plan.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	The employer self-funds a portion of the out of pocket maximum under the major medical plan. **In-network out of pocket maximum**: **$1,000** person/ **$2,000** family **Out-of-network out of pocket maximum:** **$1,000** person/ **$2,000** family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on this plan, they have to meet their own out of pocket limits until the overall family out of pocket limit has been met.

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

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

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

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

Excluded Services & Other Covered Services:

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

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

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

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

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

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

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [319-752-3200].]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [319-752-3200].]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 [319-752-3200].]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [319-752-3200].]

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

About these Coverage Examples:

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

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

The plan's overall deductible	$500
PCP copayment	$10
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,070**

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

The plan's overall deductible	$500
Specialist copayment	$10
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$50
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,070**

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

The plan's overall deductible	$500
Specialist copayment	$10
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$60
Coinsurance	$280
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$840**

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

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

City of Bondurant's
Enrollment Forms

Wellmark

Employee Application for Health Insurance (for Non-ACA Groups)

☐ Large Group
Wellmark Blue Cross and Blue Shield of Iowa
Fax: (515) 376-9047

☐ Small Business and Mid-Size Groups
Wellmark Blue Cross and Blue Shield of Iowa
Fax: (515) 376-9042

Failure to fill out this application completely may result in a delay of coverage.

☐ Open Enrollment Period ☐ Newly Eligible ☐ Special Enrollee ☐ Change

A. Employer Information (Completed by Employer)

Group/Billing Unit No._____ Department No._____ Effective Date_____/_____/_____

Employer Name_____ Phone Number (_____) _____

Employer Address Line 1 (Street Address or Suite#)_____

Employer Address Line 2 (PO Box, Street Address)_____

City_____ State_____ ZIP_____

B. Employee Information

Name (First, MI, Last)_____

Address Line 1 (Street Address or Apt/Suite#)_____

Address Line 2 (PO Box, Street Address)_____

City_____ State_____ ZIP_____

Home Phone Number (_____)_____ Work Phone Number (_____)_____ Ext._____

Email Address (optional)_____

Date of Birth _____/_____/_____ (mm/dd/yyyy) Gender: ☐ Male ☐ Female

Status: ☐ Single ☐ Married ☐ Common law ☐ Domestic partner (Certification of Domestic Partnership form, M-4328, required)

Social Security Number/Tax Identification Number _____

(Social Security Number (SSN) or Tax Identification Number (TIN) must be provided.)

Date of Hire (required)_____/_____/_____ (mm/dd/yyyy)

Employment Status: ☐ Full-Time ☐ Part-Time ☐ COBRA ☐ Retiree ☐ Seasonal

Health: ☐ Employee ☐ Employee/spouse or domestic partner
☐ Employee/child(ren) ☐ Employee/spouse or domestic partner/child(ren)

Health Plan Code:_____ **Deductible Amount:**_____

As a Wellmark contract holder, you will receive a Summary of Benefits and Coverage (SBC) that outlines important information about your coverage. You can also access Wellmark.com/Inform to help you make the best decisions for you and your family. This site includes important information on your prescription drug coverage, like the accessibility and availability of prescription drugs, how to request a current drug list and the process for requesting an exception to the drug list. You also can find a list of participating providers and facilities, and how to obtain prior authorization. For more information, or if you have any questions, you can call the Wellmark Customer Service number located on the back of your ID card.

C. Waiver of Enrollment (Please complete if you are waiving health benefits.)

☐ I waive health coverage for my dependents and myself. Please indicate one of the following reasons:
- ☐ I (We) have coverage under another health care benefit plan.
- ☐ I (We) do not wish to enroll in the health plan.

Please see the Important Information Regarding Waiver of Enrollment section on page 3 of this application.

Employee Name (First, Last)	Social Security Number / Tax Identification Number

D. Enrollment Reason or Event

Special Enrollment Event Reason:

☐ Birth
☐ Marriage/common law
☐ Divorce/dissolution of domestic partnership
☐ Adoption or placement for adoption
☐ Court-ordered coverage
☐ Legal guardianship
☐ Foster child placement
☐ Involuntary loss of creditable coverage
☐ Permanent move to Iowa
☐ Returning from military service
☐ Domestic partnership
☐ Other______________________________

List date of special enrollment event ______/______/______ (mm/dd/yyyy) (or last day of coverage)

E. Members/Enrollees Covered

If you need to list more than four dependents, please write all necessary information on a separate sheet of paper and attach to this application. Your employer determines eligibility for coverage. Please confirm with your employer that the dependent types listed below are eligible.

List Name (First, MI, Last) of all others to be covered	Date of Birth	Social Security Number/Tax Identification Number[1]	Gender	FT Student?[2]	Disabled?[2]
Spouse or Domestic Partner	/ /	a. ☐ SSN/TIN ______________ b. ☐ Does not have an SSN/TIN c. ☐ I refuse to provide the SSN/TIN	☐ Male ☐ Female	N/A	☐ Yes
Dependent	/ /	a. ☐ SSN/TIN ______________ b. ☐ Does not have an SSN/TIN c. ☐ I refuse to provide the SSN/TIN	☐ Male ☐ Female	☐ Yes	☐ Yes
Dependent	/ /	a. ☐ SSN/TIN ______________ b. ☐ Does not have an SSN/TIN c. ☐ I refuse to provide the SSN/TIN	☐ Male ☐ Female	☐ Yes	☐ Yes
Dependent	/ /	a. ☐ SSN/TIN ______________ b. ☐ Does not have an SSN/TIN c. ☐ I refuse to provide the SSN/TIN	☐ Male ☐ Female	☐ Yes	☐ Yes
Dependent	/ /	a. ☐ SSN/TIN ______________ b. ☐ Does not have an SSN/TIN c. ☐ I refuse to provide the SSN/TIN	☐ Male ☐ Female	☐ Yes	☐ Yes

[1]The IRS requires Wellmark to collect SSNs/TINs for federal reporting purposes. Wellmark or your employer will follow up with you to collect this information if you do not complete a., b., or c. for each person listed. Failure to provide the SSN/TIN information may result in a monetary penalty, per violation, assessed to you by the IRS.

[2]If your plan covers dependent(s) age 26 or older, they must be unmarried and either a full-time student or a disabled dependent. Please contact your Wellmark representative for more information.

Employee Name (First, Last)	Social Security Number / Tax Identification Number

F. Medicare Coverage (Required)

☐ Yes ☐ No Are you and/or anyone listed in Section E Social Security disabled?
If yes, list names_____

☐ Yes ☐ No Are you and/or anyone listed in Section E enrolled in Medicare?
If yes, complete the following as appropriate:

Employee Name (as it appears on Medicare card) _____ Medicare ID _____

Effective Date (Part A)_____/_____/_____ Effective Date (Part B)_____/_____/_____

Spouse or Domestic Partner Name (as it appears on Medicare card) _____ Medicare ID _____

Effective Date (Part A)_____/_____/_____ Effective Date (Part B)_____/_____/_____

Dependent Name (as it appears on Medicare card) _____ Medicare ID _____

Effective Date (Part A)_____/_____/_____ Effective Date (Part B)_____/_____/_____

G. Other Carrier Information (Required)

☐ Yes ☐ No Will you, your spouse or domestic partner, or your dependents keep other health coverage in addition to this Wellmark, Inc. coverage?
If yes, please complete the following:

Policyholder Name (First, Last)_____ Date of Birth_____/_____/_____

Please list those covered by the other health plan(s)_____

Policy No._____ Effective Date_____/_____/_____

Employer Name (if coverage is through employer group)_____

Insurance Company/HMO Name_____

Address Line 1 (Street Address or Suite#)_____

Address Line 2 (PO Box, Street Address)_____

City_____ State_____ ZIP_____

Phone Number (if known) (_____)_____

Is there a divorce decree/court order that requires one parent to provide health insurance coverage for any dependent?

☐ Yes ☐ No If yes, please complete the following:

List dependent(s)_____

List name of person required to provide health insurance_____

List name of person who has primary physical custody_____

H. Important Information Regarding Waiver Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse or domestic partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself or 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 a period of time specified by your Plan 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 the time specified by your Plan after the marriage, birth, adoption, or placement for adoption. Additionally, you must enroll within the time specified by your employer after you lose eligibility for coverage under Medicaid or CHIP or become eligible for Medicaid or CHIP premium assistance.

Employee Name (First, Last)	Social Security Number / Tax Identification Number

H. Important Information Regarding Waiver Enrollment, cont'd

Please note that if you or your dependents are not covered by minimum essential coverage, you may be responsible for individual shared responsibility payments when filing your federal income tax return. Also, by declining the coverage offered by your employer, you or your dependents may not be eligible for Marketplace coverage subsidies.

To request special enrollment or obtain more information, refer to your Summary Plan Description (SPD), coverage manual, other benefit documents, or contact your employer.

I. Authorization and Certification

I certify that I am legally authorized to apply for coverage for myself and all other persons named in this application. I understand that I am completing this application for the coverage sponsored by my employer or group sponsor and offered by Wellmark, Inc., doing business as Wellmark Blue Cross and Blue Shield of Iowa, or Wellmark Health Plan of Iowa, Inc. (each referenced herein as "Wellmark"). I authorize my employer, as my agent, to deduct from my pay or collect from me in advance the monthly rates therefore and remit such sums to Wellmark on my behalf. This authorization is to remain in effect until Wellmark is notified by me or my employer to the contrary. I understand that written notice of rate changes will be furnished to my employer as my agent. I further understand that the coverages applied for will not start until after this application and the appropriate coverage rates are received and accepted by Wellmark and an effective date of coverage is established by Wellmark.

I certify that, after this application was completed, I carefully and fully read it, that the statements and answers set forth are full, true, and correct to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that Wellmark will rely on the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or concealed any material fact, Wellmark will be entitled to declare the contracts applied for void and to refuse allowance on benefits to any person thereunder.

I acknowledge I have received or have been advised and understand I will receive from my employer the Summary of Benefits and Coverage (SBC).

Providing Social Security Numbers or Tax Identification Numbers

In order for Wellmark to report my coverage status to the federal government, I understand I must provide to Wellmark my Social Security number or tax identification number and the Social Security numbers or tax identification numbers of all members covered under my coverage. The IRS requires that Wellmark report this information using the Social Security number or tax identification number of the plan member and each dependent. If Wellmark does not have Social Security or tax identification numbers, I understand that Wellmark will be unable to report and send the information needed to complete federal tax returns. If I have not previously provided Social Security numbers or tax identification numbers to Wellmark for all members covered under my coverage, I will contact Wellmark by calling the Customer Service number on my ID card. If I do not provide the Social Security numbers or taxpayer identification numbers to Wellmark for this purpose, I may be subject to a monetary penalty per violation imposed by the Internal Revenue Service.

HSA Coverage

If the High Deductible Health Plan that I have selected is combined with a Health Savings Account (HSA), I understand that enrolling in such coverage does not guarantee that I am or will be eligible to make contributions to an HSA or that contributions can be made to an HSA on my behalf.

Consent to receive Marketing Information and Solicitations Via Residential Telephone, Cellular Phone, Text and Email Messages

By checking the box later in this application and entering my signature on this application, I hereby provide my consent to Wellmark to contact me about Wellmark products and services that may be available to me. Wellmark may provide this information to me using residential telephone, cellular telephone or wireless device, text message or email contact information provided to Wellmark from time to time. If I provide a telephone number for voice calls, I understand that Wellmark may contact me via live or prerecorded calls. I give Wellmark permission to use my personal data (including personally identifiable information) in accordance with Wellmark's privacy policy to determine the types of products and services that may be offered to me. I understand the telephone company or other communications carrier may impose charges for these contacts and that I am not required to give this consent to purchase any goods or services. I understand I may revoke this consent at any time by calling the number located on the back of my Wellmark ID card.

Consent to Electronic Delivery of Information

By checking the box later in this application and entering my signature on this application, I hereby provide my consent to Wellmark to deliver important notices and information about my health plan and coverage electronically. I understand I am being asked to consent to notices and documents being delivered to me electronically. My consent applies to notices and documents relating to my health insurance coverage ("Coverage") with Wellmark.

Employee Name (First, Last)	Social Security Number / Tax Identification Number

I. AUTHORIZATION AND CERTIFICATION, cont'd

Right to Request for Paper Copies

I understand that I have the right to have a notice or document provided or made available in paper form at no cost. To obtain a paper copy of a notice or document delivered by electronic means or to withdraw consent, please call the number on the back of your ID card.

Right to Withdraw Consent

I understand that I have the right to withdraw consent to have a notice or document delivered by electronic means. Such consent will be deemed withdrawn upon receipt by Wellmark of the request to withdraw consent. Any withdrawal of consent shall not affect the legal effectiveness, validity or enforceability a notice or document delivered by electronic means before the withdrawal of consent is effective. To withdrawal consent for electronic notice of documents please contact Wellmark by calling the number on the back of your ID card or select "unsubscribe" option located within the email message.

Scope of Consent

This consent applies to all notices and documents relating to my Coverage, including, but not limited to:

- Explanation of Benefits;
- Disclosures and notices;
- Summary of Benefits and Coverage;
- Notices of cancellation, nonrenewal or termination;
- Benefits Policy, riders or endorsements;
- Responses to communications from you;
- Appeals correspondence;
- Billing and payment notices; and
- Other important information

Hardware and Software Requirements

In order to access, view and retain documents electronically, I understand I must have access to a personal computer or other device capable of accessing the internet with a web browser, email or web service capabilities, the ability to receive and review attachments to emails and software which permits me to receive and access Portable Document Format (PDF) files and MS Word files. Free software to view PDF files is available from: http://get.adobe.com/reader/. I confirm that I have access to the hardware and software necessary to receive and review electronic records and I have an active email account with the ability to receive and access emails and email attachments in the formats described.

NOTICE/DISCLAIMER

WELLMARK IS NOT RESPONSIBLE FOR ANY UNAUTHORIZED ACCESS BY THIRD PARTIES TO INFORMATION PROVIDED ELECTRONICALLY, INCLUDING, WITHOUT LIMITATION, ANY DIRECT, INDIRECT, SPECIAL, INCIDENTAL OR CONSEQUENTIAL DAMAGES RESULTING FROM SUCH UNAUTHORIZED ACCESS. WELLMARK ALSO IS NOT RESPONSIBLE FOR DELAYS IN TRANSMISSION OF NOTICES AND DOCUMENTS.

CONSENT

By accessing or opening the documents sent to me via the email address provided, I certify that (1) I consent and agree to receive notices and documents electronically and confirm that I will download or print them for my records; and (2) I have the ability to access the information that is provided electronically via email communications.

☐ I give my permission to the licensed agent/licensed agency who is identified with this application to enter my application on line through Wellmark.com.

☐ I authorize Wellmark to contact me via residential telephone, cellular phone, text and/or email for marketing purposes (**optional**).

☐ I consent to receive important information electronically (**optional**).

I have read and understand the Important Information Regarding Waiver of Enrollment and Authorization and Certification language on this application and acknowledge receipt of a fully completed copy of this application.

Employee Signature_____ **Date** _____/_____/_____

DELTA DENTAL

DeltaVision®

Small Group Enrollment/Change Dental and Vision Application

TeamService@deltadentalia.com
www.deltadentalia.com
Fax: 1-888-558-9212
Phone: 1-877-983-3582

Group Number(Completed by Employer)*	**Effective Date (Completed by Employer)** ____/_____/_____
☐ **New Applicant** ☐ **Change of Coverage** ☐ **Name/Address Change**	**Department/EE Number**

SECTION I	**Name (First, Middle Initial, Last)**	**Social Security Number**	**Telephone** ( )

Mailing Address – Street City State Zip	**Status** ☐ Single ☐Married ☐ Other (specify)_____	**Hire Date** ___/___/___

Employer Name	**Employer Location**

SECTION II ELIGIBLE MEMBERS ELECTING COVERAGE

List self & eligible members to be covered **First Name MI Last (if different)**	**Social Security Number**	**Birthdate**	**Sex**	**Full-Time College Student**	**Disabled Status**	**Other Dental Coverage**	**Coverage Selected**
Self		___/___/__	☐ M ☐ F		Disabled? ☐Yes	☐No ☐Yes	☐ Dental ☐ Vision
Spouse		___/___/__	☐ M ☐ F		Disabled? ☐Yes	☐No ☐Yes	☐ Dental ☐ Vision
Eligible Child		___/___/__	☐ M ☐ F	☐Yes ☐No School Name:	Disabled? ☐Yes	☐No ☐Yes	☐ Dental ☐ Vision
Eligible Child		___/___/__	☐ M ☐ F	☐Yes ☐No School Name:	Disabled? ☐Yes	☐No ☐Yes	☐ Dental ☐ Vision
Eligible Child		___/___/__	☐ M ☐ F	☐Yes ☐No School Name:	Disabled? ☐Yes	☐No ☐Yes	☐ Dental ☐ Vision

Other Dental Coverage - If any person(s) on this application has other dental insurance please complete.
Contract holder:_____

_____ _____ ____/____/___ **☐ Single ☐ Family**
Name of Other Carrier(s) **Policy Number** **Effective Date** **Contract type**

SECTION III CHANGE OF COVERAGE

Please check events requiring Contract changes:

☐ **Marriage** ☐ **Death** ☐ **Divorce** ☐ **Birth/Adoption** ☐ **Drop Covered Person** ☐ **COBRA** ☐ **Terminating Benefits**

☐ **Other (explain)** _____ **Name of Affected Party** _____ **Date of Event** _____

SECTION IV AGREEMENT and CERTIFICATION

I have read and understand the Agreement and Certification and/or Waiver of Coverage language on the back of this application and acknowledge receipt of a fully completed copy of this application.

ACCEPTANCE OF COVERAGE

_____ ____/____/____
Employee Signature Date

WAIVER OF COVERAGE

☐ I waive dental coverage for my family members and/or myself. (Please indicate reason)_____

☐ I waive vision coverage for my family members and/or myself. (Please indicate reason)_____

_____ ____/____/____
Employee Signature Date

DeltaVision is offered through and underwritten by Veratrus Benefit Solutions, Inc., a wholly-owned subsidiary of Delta Dental of Iowa.

Principal®

Mailing Address
Des Moines, IA 50392-0002

Principal Life Insurance Company

Employee Enrollment & Waiver-IA

PLEASE USE BLACK INK
PLEASE ENTER DATES AS MM/DD/YYYY

Company name	Division level	Account number/unit number
CITY OF BONDURANT	ALL MEMBERS	1100507-10001

Employee Information

Name		Social security number	
Mailing address (street)		Birth date	☐ male ☐ female
(city)	(state)		(ZIP code)
Date employed full-time	Hours worked per week	Job occupation/class	Location
Email address		Phone number	

Do you have an eligible spouse or domestic partner or child(ren)?
☐ yes ☐ no

Salary amount (for owners, include business income)	Salary mode
	☐ yearly ☐ weekly ☐ hourly ☐ monthly ☐ bi-weekly

Payroll mode	Employer ZIP code	Employer county
☐ monthly ☐ semi-monthly ☐ weekly ☐ bi-weekly		

Eligible Dependent Information (Complete if you are electing benefits for your spouse or domestic partner or children)

Dependent name	Birth date	Gender	Social security number	Relationship
		☐ male ☐ female		☐ Spouse ☐ domestic partner
		☐ male ☐ female		☐ Child ☐ foster child* ☐ disabled child**
		☐ male ☐ female		☐ Child ☐ foster child* ☐ disabled child**
		☐ male ☐ female		☐ Child ☐ foster child* ☐ disabled child**
		☐ male ☐ female		☐ Child ☐ foster child* ☐ disabled child**

*If you checked foster child, was the child placed with you by an authorized state placement agency or by order of a court?
☐ yes ☐ no

**When your child, who is developmentally or physically disabled, reaches/exceeds the maximum age, an Application to Continue Disabled Child form must be completed and reviewed to determine eligibility.

Is your spouse or domestic partner employed by this company?
☐ yes ☐ no

Coverage	Employee	Spouse or Domestic Partner*	Child(ren)
NOTE: Employee coverage must be elected to elect any dependent coverage.			
Group Term Life	☒ Elect		
Voluntary Term Life (VTL) Benefit Amount:	☐ Elect ☐ Decline $_____	☐ Elect ☐ Decline $_____ **Cannot exceed 100% of the employee election**	☐ Elect ☐ Decline $_____
Short Term Disability	☒ Elect		
Long Term Disability	☒ Elect		

*NOTE: Domestic Partners can only be added if your employer allows this coverage. If enrolling a Domestic Partner, please attach a separate Declaration of Domestic Partnership/Enrollment Form Addendum (GP60450).

Group Term Life Beneficiary Designation (Complete if covered for group term life coverage.)

All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below. Additional beneficiaries can be added as an attachment.

Primary Beneficiaries:

Name	SSN	Date of birth	Relationship	Check here if a minor ☐	Percentage
Name	SSN	Date of birth	Relationship	Check here if a minor ☐	Percentage

Contingent Beneficiaries:

Name	SSN	Date of birth	Relationship	Check here if a minor ☐	Percentage
Name	SSN	Date of birth	Relationship	Check here if a minor ☐	Percentage

Voluntary Term Life Beneficiary Designation (Complete if covered for voluntary term life coverage. If you want to use the same beneficiary designation as indicated for group term life coverage above, write "same as above" in the beneficiary section below.)

All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below. Additional beneficiaries can be added as an attachment.

Primary Beneficiaries:

Name	SSN	Date of birth	Relationship	Check here if a minor ☐	Percentage
Name	SSN	Date of birth	Relationship	Check here if a minor ☐	Percentage

Contingent Beneficiaries:

Name	SSN	Date of birth	Relationship	Check here if a minor ☐	Percentage
Name	SSN	Date of birth	Relationship	Check here if a minor ☐	Percentage

The right to make future changes is reserved by the employee. If two or more beneficiaries are named, the proceeds shall be paid to the named beneficiaries, or to the survivor or survivors, in equal shares, unless specified otherwise.

If any beneficiary is designated as trustee, it is understood and agreed that Principal Life Insurance Company shall not be a party to nor bound by the conditions of any trust and payment of the net proceeds of said policy on the death of the insured to the then designated beneficiary shall be a complete discharge as to Principal Life.

If you have designated a minor child(ren) as your beneficiary, you must complete the Uniform Transfers to Minors Act form (GP55229).

NOTE: You are covered by both group term life and voluntary term life coverage and if you only indicate a beneficiary designation for one of these, the facility of payment provision in the group policy will be used to determine how proceeds will be paid for the other coverage.

Declining Coverage

Important! If declining any coverage for yourself or any dependent, give reason. Covered under:

- ☐ spouse's or domestic partner's group coverage
- ☐ other coverage offered by my employer
- ☐ individual insurance
- ☐ other _____

Employee Agreement (Read and sign)

I understand and agree with the following statements:

- My dependents are not eligible for coverages I don't have. My dependents, including step and foster children and any over the maximum age, are eligible based on plan provisions but those over the maximum age will be verified when a claim is filed.
- If I refuse coverage, I cannot enroll after retirement.
- If I refuse life, disability, or critical illness coverage, I may apply later but I must show proof of good health and coverage will be subject to approval by Principal Life Insurance Company.
- If the group policy does not require my contribution, I cannot decline coverage unless the policy indicates otherwise.
- If the group policy requires my contribution, I authorize my employer to deduct from my pay.
- I represent all information on this form and attachments is complete and true to the best of my knowledge. They are part of this request for coverage. I agree Principal Life is not liable for a claim before the effective date of coverage and all policy provisions apply. I have read, or had read to me, the information and my answers on this form. During the first two years coverage is in force, fraud or intentional misrepresentations can cause changes in my coverage, including cancellation back to the effective date.
- Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.
- I authorize Principal Life to release data as required by law. If signed in connection with an application, reinstatement or a change in benefits, this form will be valid two years from the date below. I may revoke authorization for information not yet obtained. I understand data obtained will be used by Principal Life for claims administration and determining eligibility for life, disability, and critical illness. Information will not be used for any purposes prohibited by law.
- I understand that as the employee, the insurance I and my dependents have applied for will begin on the effective date of coverage provided I am at work on that date. If I am not actively at work on such date, subject to the terms of the group policy, coverage may not go into effect until after my return to work. Furthermore, I understand that no insurance may become effective for any member of my family while he/she is in a period of limited activity.

A copy of this form will be as valid as the original.

I declare that the information I have completed on this enrollment form is complete and true. I understand an agent or broker cannot guarantee coverage, revise rates, benefits or provisions without written approval from Principal Life Insurance Company.

Your signature X_____ **Date Signed** _____

Instructions

After this form is completed and signed, make two copies and send the original to Principal Life Insurance Company:

- One for the employee
- One for the employer

ICMA-RC is now

MissionSquare RETIREMENT

457 Deferred Compensation Plans Contribution Form

- Use this form to initiate or change the amount you contribute to your 457 deferred compensation plan account with MissionSquare Retirement.
  Note: *You should only use this form if you have previously established an account in your employer's plan.*
- Return the completed form to your employer.

YEAR	MAXIMUM CONTRIBUTION	AGE-50 CATCH-UP	PRE-RETIREMENT CATCH-UP
2022	**$20,500** *Approximately $788 every two weeks** **If you are paid semi-monthly (24 pay periods per year), contribute $854 per pay period.*	**$6,500** *$27,000 total*	**$20,500** *$41,000 total*

1 PARTICIPANT INFORMATION

EMPLOYER PLAN NUMBER:	EMPLOYER PLAN NAME:	STATE:

IDENTIFICATION *PLEASE PROVIDE YOUR **SOCIAL SECURITY NUMBER** OR **EMPLOYEE ID***	SOCIAL SECURITY NUMBER:	◆ OR ◆	EMPLOYEE ID:
FULL NAME: *LAST, FIRST, MI*		EMAIL ADDRESS:	

2 CONTRIBUTION AMOUNT AND EFFECTIVE DATE

Contribution Amount: *(per pay period)*

I authorize my employer to contribute the amount specified below from my pay each pay period, to be contributed to my 457 deferred compensation plan account with MissionSquare Retirement. *(Specify a percentage or dollar amount for pre-tax and/or Roth contributions.)*

☐ Pre-Tax Contributions: ☐ Percentage: _____% ***OR*** ☐ Dollar Amount: $_____ *(per pay period)*

☐ Roth Contributions: ☐ Percentage: _____% ***OR*** ☐ Dollar Amount: $_____ *(per pay period)*

Roth contributions are not available in all plans. Please check with your employer or MissionSquare to confirm that Roth contributions are offered in your plan before selecting this option.

Normal Contribution Limit (2022): 100% of compensation or $20,500, whichever is less.

Catch-up Contributions:

If you are taking advantage of either of the catch-up contribution provisions available to 457 plan participants, please check the applicable box below.

☐ Age 50 catch-up contributions (up to $6,500 more than the normal limit. $27,000 maximum.)

☐ Special pre-retirement catch-up (up to $20,500 more than the normal limit. $41,000 maximum.)
Please read MissionSquare's ***457 Deferred Compensation Plan Pre-Retirement Catch-Up Form*** for more information.

Effective Date:

All contribution changes will be effective as of the first pay period of the calendar month following the date you submit this form to your employer, or as soon as administratively possible thereafter, unless a later date is specified below.

- Future Effective Date *(cannot be earlier than the beginning of the following month)*: *MM/DD/YYYY* _____

3 SIGNATURES

Participant Signature: _____ Date: *MM/DD/YYYY* _____

Employer Signature: _____ Date: *MM/DD/YYYY* _____

MissionSquare Retirement ■ Attn: Workflow Management Team ■ P.O. Box 96220 ■ Washington, DC 20090-6220 ■ Toll Free 800-669-7400 ■ www.missionsq.org ■ Fax (202) 682-6439

54995-1121-360