2025

Benefits Guide

For the employees of

BENTON COUNTY
MINNESOTA

PLAN YEAR:
January 1, 2025 –
December 31, 2025

TABLE OF CONTENTS

At Benton County, we strive to offer a comprehensive benefits package that helps you and your family maintain health and well-being - both physically and financially.

This Guide summarizes the benefits available to you and your family. There are other important documents that you should read and understand before enrolling in group benefits. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of any discrepancy between this Guide and the actual plan documents, the actual plan documents will prevail.

How To Use This Employee Benefit Guide

Each benefit plan section will explain when you can enroll, when elected benefits will be effective, and which family members you can enroll in benefits.

When you see these terms in this Guide, this is what we mean:

- "**We**", "**Our**" - Benton County
- "**You**", "**Eligible employees**" - You may be eligible for insurance plans depending on how many hours you work per week and/or your full-time/part-time employment status.
- "**Dependents**" – This generally refers to your spouse and child(ren) and may include other family members such as a stepchild or disabled dependent.
- "**Premium**" – The cost of insurance.
- "**Copayment**" - A fixed amount that you pay for a health care service, dependent on which plan you select. It is paid directly to the provider and is generally due at the time services are rendered.
- **"Deductible"** - A deductible is a pre-determined amount that is paid by you before the medical insurer begins to pay.
- **"Coinsurance" -** Coinsurance is your share of the costs of a healthcare service expressed as a percentage. Coinsurance is typically paid by you after you meet your deductible (if applicable).
- **"Out-of-Pocket Limit" -** The out-of-pocket limit is the most you will spend toward your medical expenses in a plan year.

Some benefits in this Guide are income tax-advantaged and subject to U.S. Internal Revenue Service (IRS) Code. However, no language in this Employee Benefit Guide is intended, nor should be construed as tax advice. Please consult your personal tax preparer, accountant or financial planner with any questions regarding benefit taxability.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal Law gives you more choices about your prescription drug coverage. Please see page 54 for more details.

IMPORTANT CONTACT INFORMATION

If you have any questions about any of your benefits, please contact Human Resources.

The information in this Employee Health & Wellness Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to provide an accurate summary of benefits, errors are possible. In case of any discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996.

MEDICAL – BlueCross BlueShield of MN

Group Number 10756722

Customer Service	866-543-5966
Website	www.bluecrossmn.com

TELEMEDICINE & VIRTUAL COUNSELING – First Stop Health

Customer Service	888-691-7867
Website	www.fshealth.com

HEALTH SAVINGS ACCOUNT (HSA) – WEX

Group Number 45774

Customer Service	833-225-5939
Website	www.wexinc.com

VEBA – WEX

Group Number	45774
Customer Service	833-225-5939
Website	www.wexinc.com

FLEXIBLE SPENDING ACCOUNT (FSA) – WEX

Group Number	45774
Customer Service	833-225-5939
Website	www.wexinc.com

DENTAL – Guardian

Group Number	00071144
Customer Service	800-541-7846
Website	www.guardianlife.com

HOW TO ENROLL IN BENEFITS

IMPORTANT! You must enroll in benefits before the deadline in order for benefits to be effective. If you do not enroll when you are first offered coverage, you must wait until the next Annual Open Enrollment Period or you experience a qualified life event.

Your Benefits

Benton County strives to provide you and your family with a comprehensive and valuable benefits package. We want to make sure you're getting the most out of our benefits and this guide will outline all of the different benefits Benton County offers, so you can identify which offerings are best for you and your family.

When To Enroll in Benefits or Make Plan Changes

You can sign up for benefits or make plan changes for yourself and your dependents at any of the following times:

- Within 30 days from the date you are first eligible to participate.
- During the designated Annual Open Enrollment Period.
- Within 30 days of a qualified life event.

Eligibility

Refer to each plan overview for eligibility.

How to Enroll in Benefits

Human Resources will provide new hires with enrollment instructions.

Qualified Life Events – How to Make Changes

The following are some qualified life events that allow you to change your benefits mid-year. Any change in:

- Your **legal marital status**: marriage, legal separation, divorce, death of spouse.
- Your **number of dependent children**: birth, adoption, placement for adoption, death of child.
- Your **entitlement to Medicare.**
- You or your dependent's **eligibility or loss of assistance under Medicaid or a State Children's Health Insurance Program (CHIP)***.
- You or your spouse's **employment status**: gaining or losing eligibility under the benefit plan(s) such as moving from full-time to part-time status or vice versa or an unpaid leave of absence.
- Your **dependent's eligibility**: child reaching benefit plan maximum age limit or court decree requiring coverage under our plan

If you anticipate any of these changes or those noted in the HIPAA Special Enrollment Rights Notice in the Required Notices section of this Guide, please see Human Resources in advance of the event to verify your right to change plan coverage(s).

- Allows for a 60 day enrollment in our plan from the date of loss of coverage.

If you do not notify HR and complete a Life Event Change Form within 30 days of qualifying event, you will have to wait until the next annual open enrollment period to make benefit changes.

If you have any questions about the benefits Benton County provides, eligibility, enrollment or a qualifying life event, please contact Human Resources.

MEDICAL INSURANCE

Read this section to increase your understanding of the rules that govern this program, including a brief summary of benefits, dependent eligibility and cost of coverage.

Carrier:

- BlueCross BlueShield of MN

Plan Effective Date:

- January 1, 2025 – December 31, 2025

Eligibility:

- Full-Time employees working at least 30 hours per week or more
- New Hires are eligible on the 1st of the month following Date of Hire.

Eligible Dependent(s) Include:

- Your current legal spouse
- Your natural, adopted child or stepchild to age 26 regardless of marital or student status
- Your unmarried dependent children over age 26 who are physically or mentally handicapped and unable to care for themselves
- Refer to the BCBS SPD for additional details

Plan Options:

- $3000/$6000 Deductible Plan (VEBA Plan)
- $3300/$6000 Deductible Plan (HSA Plan)

When Elected Benefits Begin

The first day an employee is eligible under the plan or the effective date of a qualified life event.

The next few pages provide brief summaries of your current health plan options. Please see the Summary of Benefits and Coverage for more information about specific plan coverages. As always, see your Certificate of Coverage provided to you by BCBS for complete benefits.

The cost of this benefit is paid by the Employee AND your Employer.

If it's possible, seeing an in-network provider will help you save significantly.

Important! Stay In-Network

In-network providers have an arrangement with your insurance company and it will be less expensive for you to see them.

Your medical network is made up of:

- convenience care (quick) clinics
- physicians
- facilities (urgent care, emergency room)
- nurse practitioners
- specialists (dermatologists, cardiologists) at different locations, *as well as pharmacies*.

If you choose to see an out-of-network provider or pharmacy, you will still be able to use insurance, however, your costs will be ***substantially*** higher or not covered at all – meaning you pay the full bill.

In addition, the amount doesn't count toward your in-network, out-of-pocket maximum.

When you see an in-network provide, you will:

- have lower health care costs for medical services and prescription drugs.
- not need to obtain pre-authorization before a procedure such as surgery, your in-network provider will handle this on your behalf.
- not have to worry about paying for balance-billed charges and charges above the usual, reasonable, and customary.
- not have to fill out forms to send to the insurance carrier in order to receive reimbursement, your in-network provider will handle this on your behalf.

How do I find a provider in my network?

To find a doctor, log on to www.bluecrossmn.com. On the top of the page, select "Find a Doctor". In the drop down list, you will select "Find a Doctor", and select Find a Doctor one more time to under Employer-provided or individual & family plans. Click Network at the top to search the Aware Network (BlueCard PPO Network if you are searching outside of MN). Enter your search criteria. When the results display, you can refine your search criteria

When will I receive my ID card?

You will receive your ID card two to three weeks after your enrollment has been processed. If you need medical coverage before receiving your ID card, call customer service at 866-543-5966.

Once you received your Member ID Card, be sure to register for My Account at www.bluecrossmn.com.

MEDICAL PLAN SUMMARY

$3,000/$6,000 Deductible Plan (VEBA Plan)

Below is a brief overview of the **In-Network** benefits. Please see the Summary of Benefits and Coverage for out-of-network benefits and more in-depth information about specific plan coverages. As always, see your Certificate of Coverage provided to you by BCBS for complete benefits.

$3000/$6000 Deductible Plan (VEBA Plan)	In-Network
Deductible (Calendar year – Embedded) Single Family	 $3,000 $6,000
Maximum Out-of-Pocket Including Deductible Individual Family	 $3,000 $6,000
Preventive Care/Screening/Immunizations	No charge: *Deductible does not apply*
Office Visits	100% after deductible
Convenience Care	100% after deductible
Urgent Care	100% after deductible
Specialist Visit	100% after deductible
Emergency Room	100% after deductible
Diagnostic Test (x-ray, blood work)	100% after deductible
Imaging (CT/PET scans, MRIs)	100% after deductible
Hospital – Inpatient / Outpatient	100% after deductible
Mental & Behavioral Health / Substance Abuse Services	100% after deductible
Delivery and All Inpatient Services	100% after deductible
PT / OT / Speech Therapy	100% after deductible
Prescription Drugs Generic Preferred Brand Name Non-Preferred Brand Name Specialty Drugs	Retail: $12 copay $24 copay $24 copay Mail: 2x retail price Member pays 20% coinsurance up to $200 per prescription or refill, deductible does not apply

Retail: 31-day supply per prescription
Mail: 93-day supply per prescription

The purpose of this summary is to provide you with a brief overview of the benefits provided under each plan. For more detailed information, please refer to your Summary Plan Description. Although every effort was made to provide an accurate comparison, errors are possible. If information between this summary and your Summary Plan Description are conflicting, the information contained within the Summary Plan Description will prevail.

MEDICAL PLAN SUMMARY

$3,300/$6,000 Deductible Plan (HSA Plan)

Below is a brief overview of the **In-Network** benefits. Please see the Summary of Benefits and Coverage for out-of-network benefits and more in-depth information about specific plan coverages. As always, see your Certificate of Coverage provided to you by BCBS for complete benefits.

$3300/$6000 Deductible Plan (HSA Plan)	In-Network
Deductible (Calendar year – Embedded) Single Family	 $3,300 $6,000
Maximum Out-of-Pocket Including Deductible Individual Family	 $3,300 $6,000
Preventive Care/Screening/Immunizations	No charge: *Deductible does not apply*
Office Visits	100% after deductible
Convenience Care	100% after deductible
Urgent Care	100% after deductible
Specialist Visit	100% after deductible
Emergency Room	100% after deductible
Diagnostic Test (x-ray, blood work)	100% after deductible
Imaging (CT/PET scans, MRIs)	100% after deductible
Hospital – Inpatient / Outpatient	100% after deductible
Mental & Behavioral Health / Substance Abuse Services	100% after deductible
Delivery and All Inpatient Services	100% after deductible
PT / OT / Speech Therapy	100% after deductible
Prescription Drugs Generic Preferred Brand Name Non-Preferred Brand Name Specialty Drugs	Retail/Mail: 100% after deductible 100% after deductible

Retail: 31-day supply per prescription
Mail: 93-day supply per prescription

The purpose of this summary is to provide you with a brief overview of the benefits provided under each plan. For more detailed information, please refer to your Summary Plan Description. Although every effort was made to provide an accurate comparison, errors are possible. If information between this summary and your Summary Plan Description are conflicting, the information contained within the Summary Plan Description will prevail.

Preventive Eye Care

With your election in Benton County's medical plan offered through BCBS, you have access to valuable preventive vision care.

Below is a brief overview of the **In-Network** benefits. Please see the Summary of Benefits and Coverage for out-of-network benefits and more in-depth information about specific plan coverages. As always, see your Certificate of Coverage provided to you by BCBS for complete benefits.

Must use providers within the BCBS vision networks for In-Network benefits.

Contact Human Resources for information on Benton County's comprehensive dental plan through Guardian.

$3000/$6000 VEBA Plan $3300/$6000 HSA Plan	**In-Network**
Covered Adults & Dependent Children – per person (per calendar year)	
100% of *eligible charges. Deductible does not apply*	
Routine Eye Exam	*Limit 1 visit per year*

Why Use Preventive Care?

Preventive care is important because it helps you stay healthy and access prompt treatment when necessary, and it can also help reduce your overall medical expenses.

The purpose of this summary is to provide you with a brief overview of the benefits provided under each plan. For more detailed information, please refer to your Summary Plan Description. Although every effort was made to provide an accurate comparison, errors are possible. If information between this summary and your Summary Plan Description are conflicting, the information contained within the Summary Plan Description will prevail.

MEDICAL PLAN EMPLOYEE CONTRIBUTIONS

The following premiums reflect the **Monthly Employee** contribution. If you elect to participate in the medical insurance plan offered by Benton County, the following premiums are deducted on a pre-tax basis from your paycheck based on which plan you elect.

This Table Applies to: Non-Union

See the Summary of Benefits and Coverage or Certificate of Coverage for detailed information on each BCBS plan.

Plan 1: VEBA Plan		
	Single	**Family**
County Contribution to VEBA	$125.00	$250.00
County Contribution to Premium	$673.52	$1,799.78
Total County Contribution (Premium + VEBA)	$798.52	$2,049.78
Employee Contribution	$168.38	$599.93
Total Premium	$841.90	$2,399.71

Plan 2: HSA Plan		
	Single	**Family**
County Contribution to VEBA	$125.00	$250.00
County Contribution to Premium	$617.25	$1,649.45
Total County Contribution (Premium + HSA)	$742.25	$1,899.45
Employee Contribution	$154.31	$549.81
Total Premium	$771.56	$2,199.26

2025 Health Insurance

All Employee Rates

Monthly Premium Contributions

VEBA Plan

	Single	Family
County Contribution to VEBA	$ 125.00	$ 250.00
County Contribution to Premium	$ 673.52	$ 1,799.78
Total County Contribution *(Premium + VEBA)*	$ 798.52	$ 2,049.78
Employee Contribution	$ 168.38	$ 599.93
Total Premium	$ 841.90	$ 2,399.71
Previous year total premium	$ 841.90	$ 2,399.71

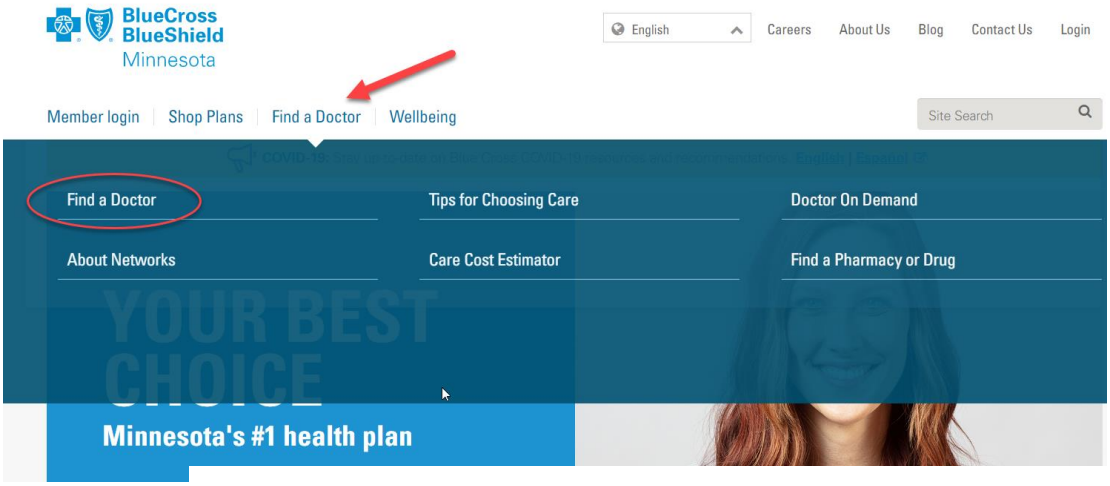
HSA Plan

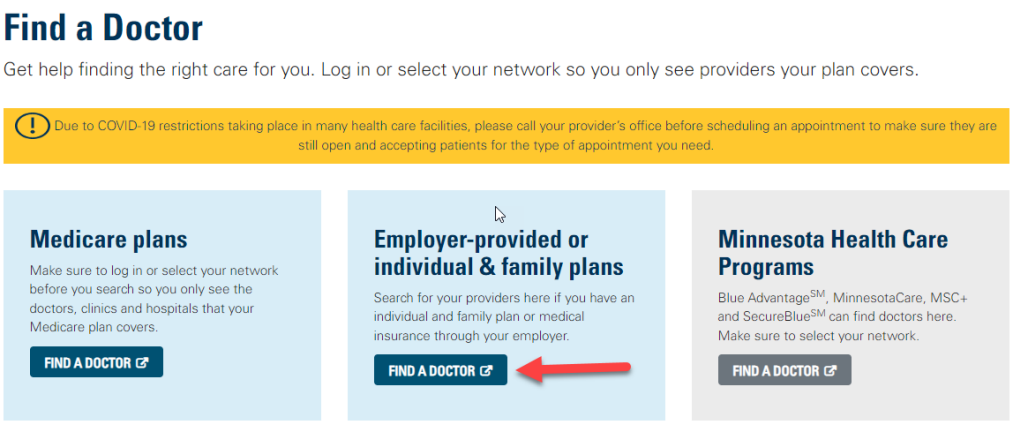
	Single	Family
County Contribution to HSA	$ 125.00	$ 250.00
County Contribution to Premium	$ 617.25	$ 1,649.45
Total County Contribution *(Premium + HSA)*	$ 742.25	$ 1,899.45
Employee Contribution	$ 154.31	$ 549.81
Total Premium	$ 771.56	$ 2,199.26
Previous year total premium	$ 771.56	$ 2,199.26

THINKING OF BECOMING A MEMBER

Individuals have access to search as a GUEST for in-network providers and verify if their prescription drugs are on our formulary drug list

- ☐ Go to https://www.bluecrossmn.com/
- ☐ Hover over Find a Doctor
- ☐ Click Find a Doctor

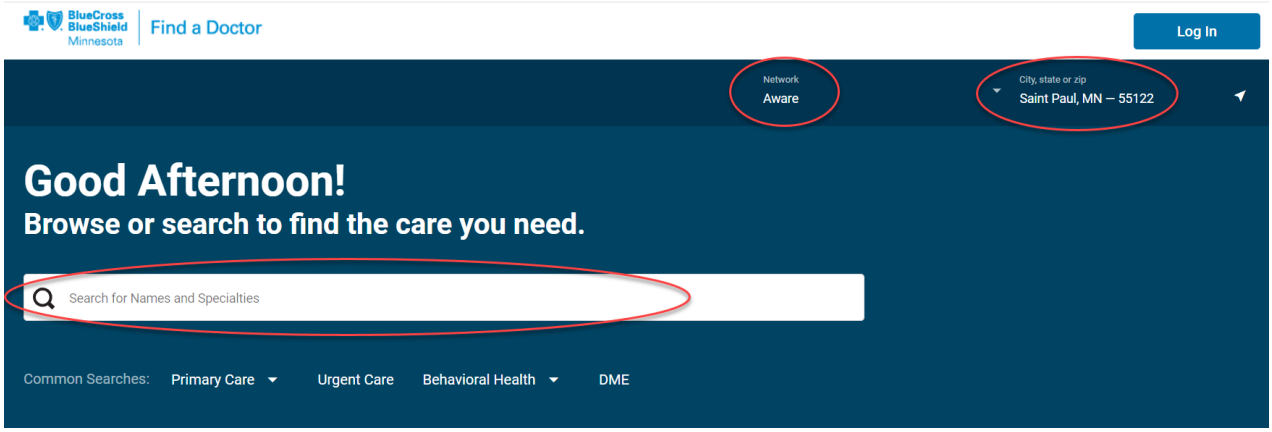




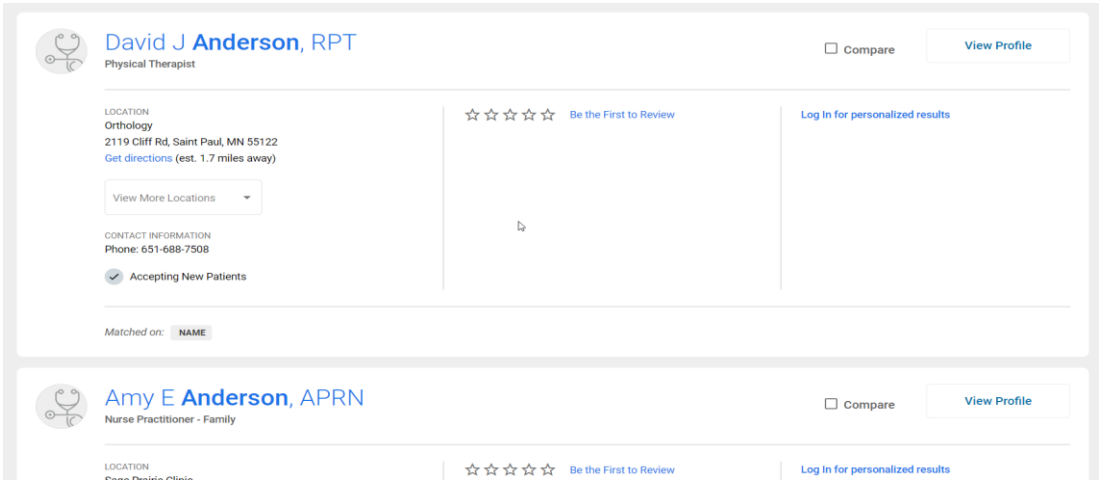
- ☐ Click Find a Doctor one more time under Employer-provided or individual & family plans

FIND A DOCTOR, HOSPITAL OR OTHER MEDICAL PROVIDER

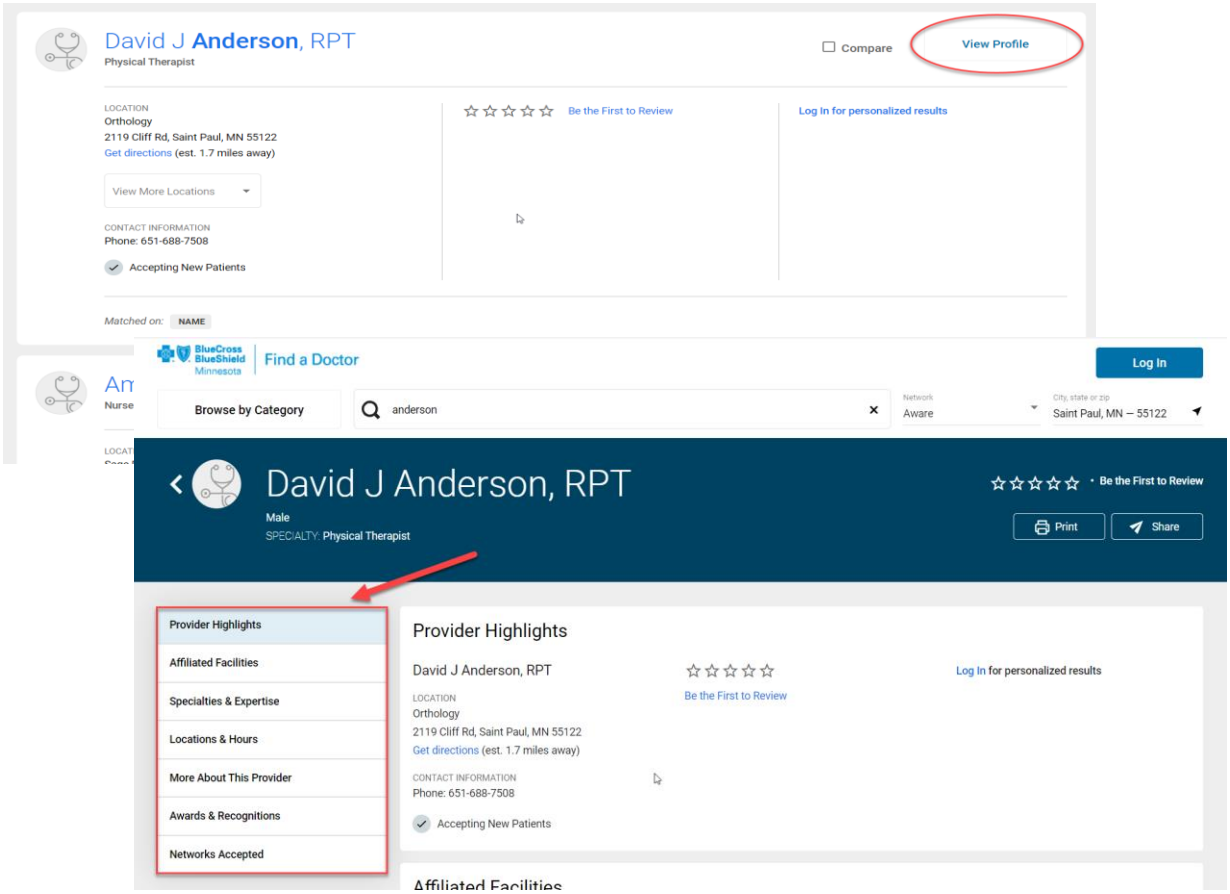
- ☐ Click Network at the top of the Find a Doctor tool
- ☐ Select appropriate network from the drop down list
  - BlueCard PPO (National Network)
  - Aware (MN local network)
- ☐ Type in your city or zip code. Please note: If your locations are turned on in your internet settings, your current location may already be listed
- ☐ Type a doctor's name, hospital, clinic, specialty, or condition in the search box
- ☐ Hit enter on your keyboard to search



- ☐ Results will populate. Individuals have the ability to filter their search criteria further

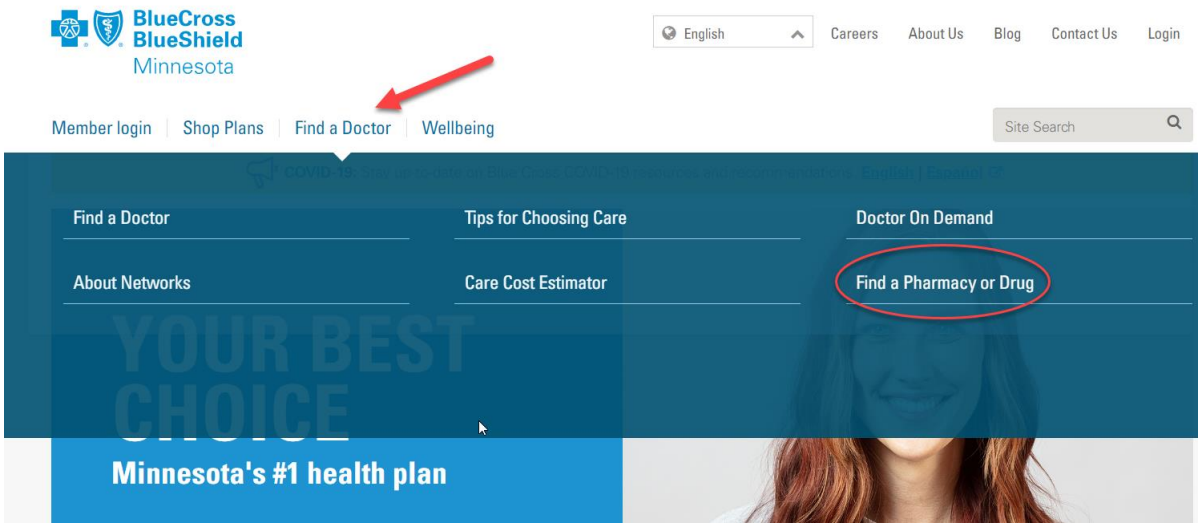


- You can click View Profile to see further details such as, if a provider practices at multiple locations, what hospitals they are affiliated with and if they are accepting new patients

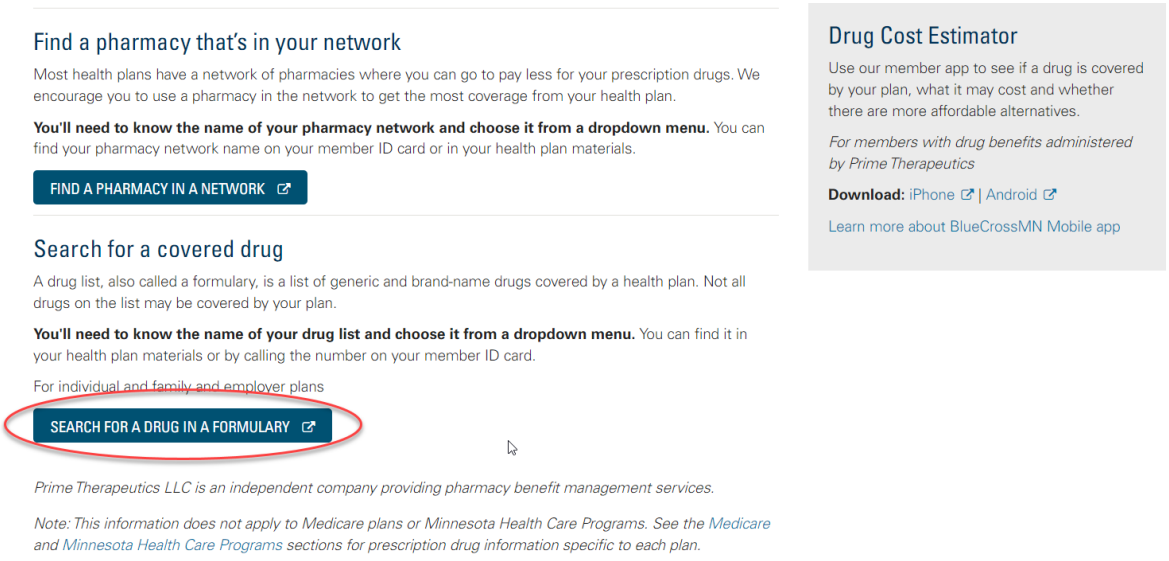


FIND A DRUG

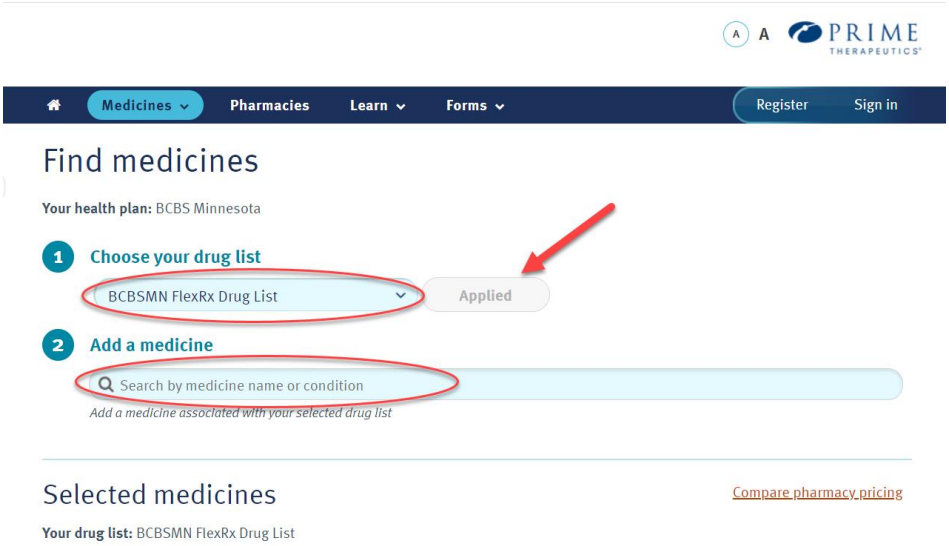
- ☐ Go to https://www.bluecrossmn.com/
- ☐ Hover over Find a Doctor
- ☐ Click Find a Pharmacy or Drug



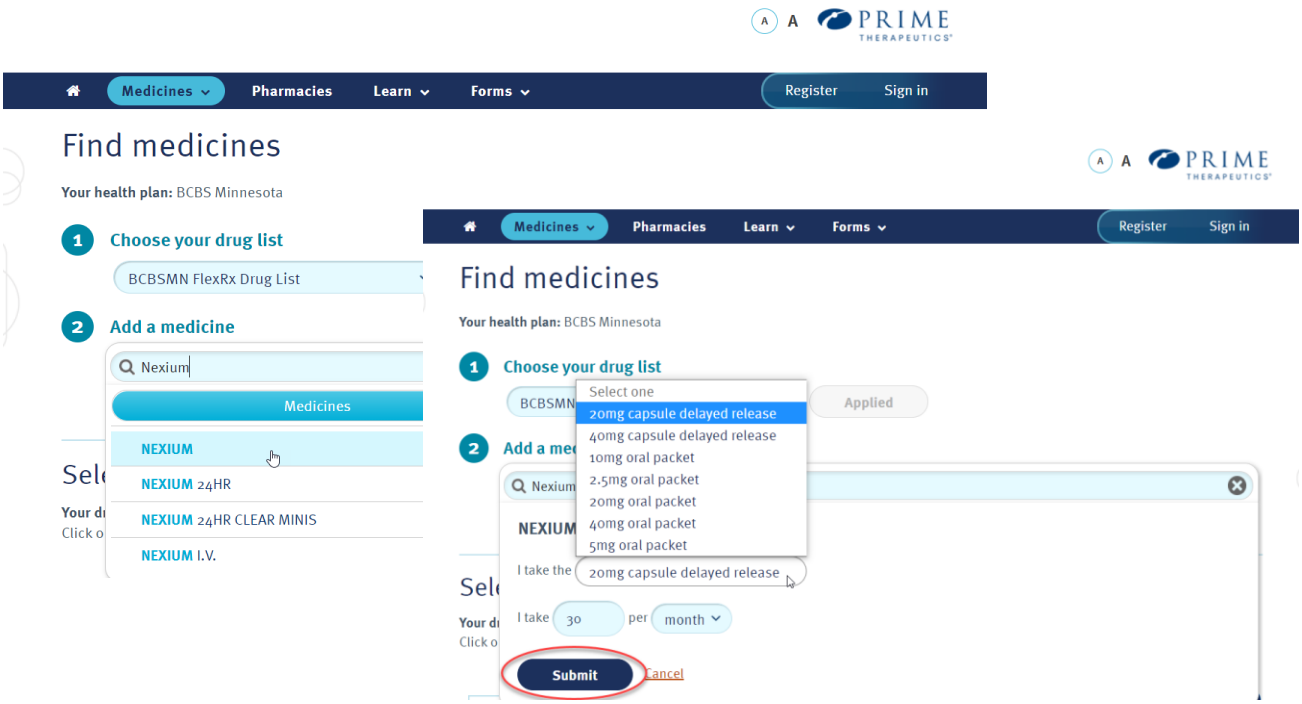
- ☐ Scroll to the bottom of the Find a pharmacy or search drug list page
- ☐ Click Search for a drug in a formulary



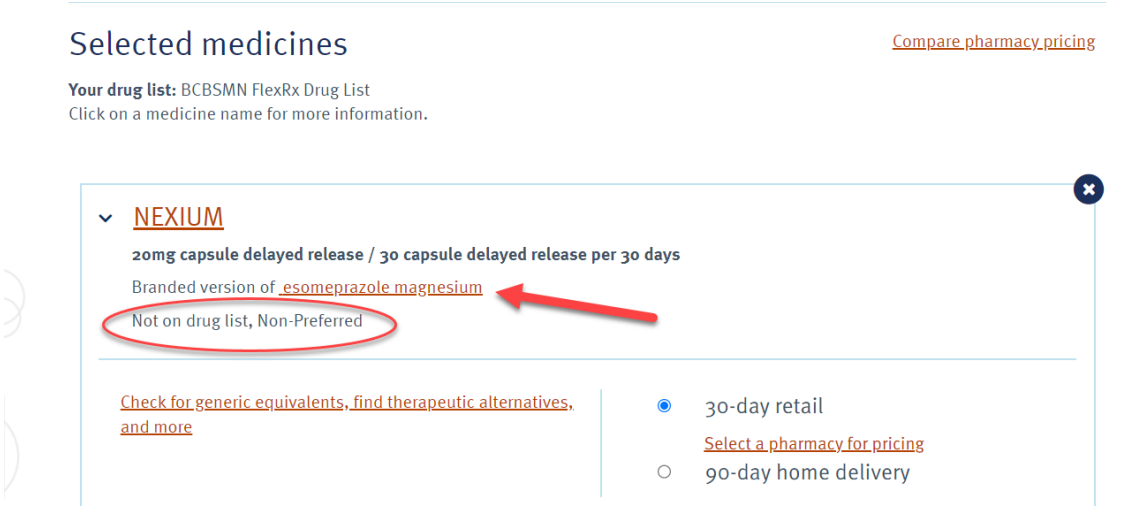
- You will be automatically routed to the Prime Therapeutics website:
  - Choose your drug list from the drop down: BCBSMN FlexRx Drug List
  - Click Apply

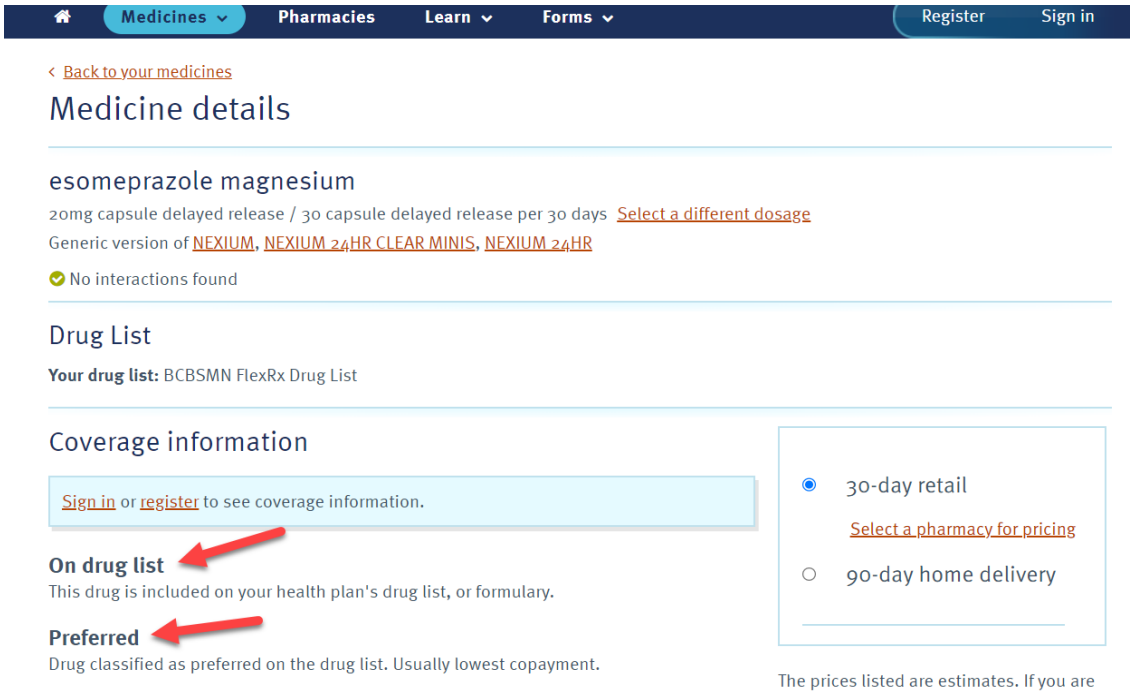


- Type the name of the medication in the Add a medicine field
  - Select the specific name of the medication when it populates
  - Choose the dosage and click "Submit"



- The result(s) will populate and indicate:
  - if it is a Preferred or Non-Preferred Drug.
- If your drug is Non-Preferred, there may be a Preferred generic alternative
- Click on the associated drug name





BlueCross BlueShield Minnesota

BLUE CARE ADVISOR℠ APP

Getting the most out of your Blue Cross benefits

GETTING STARTED WITH YOUR BLUE CARE ADVISOR APP

Blue Care Advisor lets you connect online to all your benefits, claims, and get personalized recommendations on steps you can take to improve your health.

Blue Care Advisor's mobile app works on most devices and is available for iPhone or Android. If you already have a Blue Cross and Blue Shield of Minnesota member account, you can still use the same username and password for the Blue Care Advisor mobile app.

ONCE YOUR HEALTH BENEFITS ARE ACTIVE, YOU CAN SET UP YOUR ACCOUNT

1 Install the app for free

From the Apple App Store or Google Play, download the correct app by typing, **Blue Care Advisor**, in the search, then click on the GET button to install the app.

Or scan this QR code using your phone's camera

2 Register to set up your personal account

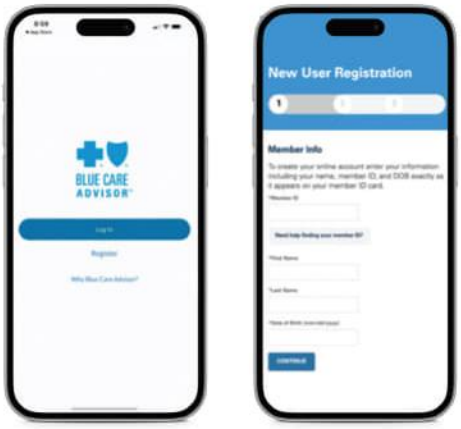
If you do not already have an online member account, you will need to register. You will need your member ID from your Blue Cross member ID card that is mailed to you to set up your account.

3 Create your username and password

Follow the steps on your screen. **The email address must be unique to you** (meaning the same email address cannot be used for more than one person on your health plan).

4 Get your verification code and finish your set up

You will receive a code to the email address you provided within a few minutes. After entering the code, your account set up is complete.



WE ARE HERE TO HELP

Please call Blue Cross customer service at the number listed on the back of your member ID card with any questions about setting up your account or your benefits.

M07990 (6/23)

BlueCross BlueShield Minnesota

A NEW WAY TO SAVE ON MEDICINE

Home delivery from Amazon Pharmacy

A quick and easy way to get your medicines[1] delivered at home.

As a Blue Cross and Blue Shield of Minnesota member, you have access to MedsYourWay™, a prescription drug discount card program.[2] With MedsYourWay you'll have up to 80 percent savings[3] on brand and generic medicines[4] and it's seamlessly built into the Amazon Pharmacy experience.

SHOP

Easy to use

Amazon Pharmacy makes it easier because it's just like shopping on Amazon.com.

- Easy sign-up, which includes the option to have your account auto-populated with your prescription history
- Option for 90-day fills
- Pharmacist on call 24 hours a day, seven days a week
- Ability to manage your medicine and view order history

SAVE

Built-in drug discount card

Some drugs may be available at lower prices with a discount card. MedsYourWay discount card pricing is built right into the Amazon Pharmacy experience — no card required.

- At checkout, you'll see the lowest cost available for your medicine. That's the price you'll pay.
- MedsYourWay discount card pricing is not insurance. However, all prescribed and covered purchases[5] automatically count toward your annual out-of-pocket maximum — whether you're paying a copay or using the discount card pricing.

SHIP

Free home delivery

Skip the pharmacy line with home delivery.

- Free, fast delivery: Amazon Prime members get two-day free shipping on most orders. Standard free shipping for non-Amazon Prime members is five days but can be expedited to two-day delivery for $5.99.
- Real-time package tracking from order to delivery

[1]Amazon Pharmacy does not dispense Schedule 2 controlled substance drugs.

[2]MedsYourWay prescription drug discount card, administered by Inside Rx LLC, is not insurance. You are responsible for the cost of prescription(s) when using the card. Limitations apply.

[3]Average savings based on usage and Inside Rx data as compared to cash prices; average savings are up to 80 percent for all generics and 37 percent for select brand medicines. Restrictions apply.

[4]Non-specialty medicines only.

[5]If your medicine has an unfulfilled requirement, the cost may not count toward your (accumulator) out-of-pocket maximum. Typical requirements include prior authorization (PA) needed, quantity limit exceeded or step therapy needed.

GET STARTED TODAY

Save time and money with MedsYourWay. Scan the QR code with your camera to get a link or visit **amazon.com/bluecrossmnMYW** and click “Get started.”

QUESTIONS?

Call Amazon Pharmacy Customer Care at **1-855-206-2430**, Monday through Friday, 7 a.m. to 9 p.m. Central Time and Saturday and Sunday, 9 a.m. to 7 p.m. Central Time.

MedsYourWay is part of Amazon Pharmacy, an independent company offering pharmaceutical home delivery services.

M06684 (4/22)

First Stop Health

BENTON COUNTY
MINNESOTA

24/7 care when you need it.

Get convenient care for your body and mind — all via phone or video. Benton County provides First Stop Health to benefits-enrolled employees and your dependents for free.

On-demand doctor visits

Getting the care you need shouldn't be a pain. Our board-certified doctors are available 24/7 via phone or video!

Diagnosis & treatment

Get immediate support, including prescriptions when appropriate* for:

- Sore Throat
- Cough
- Sinus Issues
- Skin Rash
- UTI
- Rx Refill*
- Pink Eye
- Fever
- Earache
- Cold & Flu
- Medical Questions
- And more!

Counseling for your mental health.

Use short-term, solution-focused counseling for anxiety, depression, grief and more.

Activate your account

Use the last 4 digits of your SSN to claim your account!

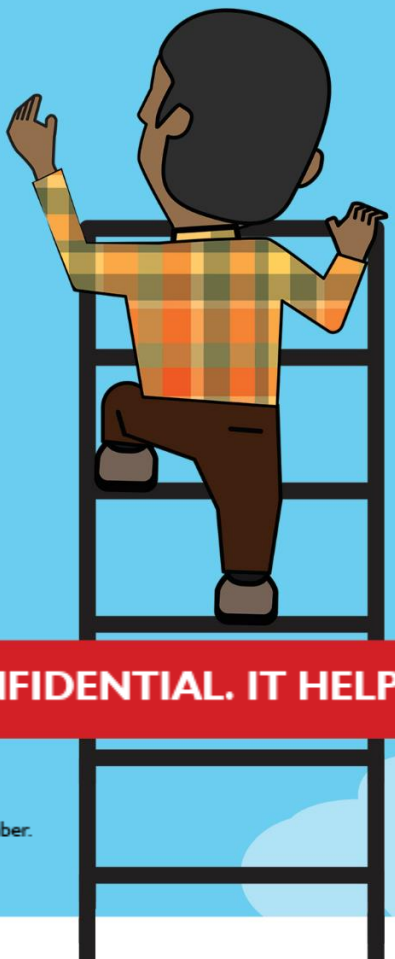
firststophealth.com | 888-691-7867

*First Stop Health services are not intended to constitute a health plan. *Providers at First Stop Health do not prescribe controlled substances. Costs according to your medical plan may apply for prescriptions. For those under the age of 18, virtual counseling use will be considered on a case-by-case basis.*

It's OK to Ask for Help

Everyone needs support at some point. When you need it, call the Employee Assistance Program.

The EAP offers confidential counseling with no judgment. Support is provided at no cost to you, your spouse and dependents.



Contact the EAP Today

PHONE 1.800.550.6248

ONLINE SandCreekEAP.com

YOUR EAP IS SIMPLE TO USE. IT IS CONFIDENTIAL. IT HELPS.

Employees, their spouses and dependents have access to no-cost counseling services statewide through their employment with an MCIT public entity member.

Employee Information

EMPLOYEE ASSISTANCE PROGRAM

EAP

No-cost, convenient and confidential counseling

EAP Counseling Is ...

VOLUNTARY: You decide when to use the program's services.

CONFIDENTIAL: Your personal information will not be shared with your employer. Only you know when you call for assistance.

NO-COST: You, your spouse and your dependents are eligible for up to six counseling sessions for each identified problem at no-cost.

CONVENIENT: Hundreds of counseling offices are available statewide and over the phone, so you, your spouse and dependents have easy and timely access to a qualified counselor where you choose.

MCIT

Call 1.800.550.MCIT (6248) for counseling services

What Is an EAP?

The Employee Assistance Program (EAP) is a risk management program designed to help employees identify and resolve challenges that may impair their performance at work. It is a voluntary program that can assist you (the employee), your spouse and dependents with difficult personal issues through access to professional counselors.

What Does the EAP Do?

- Helps employees find professional assistance for personal problems
- Offers short-term counseling for you, your spouse and your dependents at no cost
- Uses pre-approved qualified counselors throughout Minnesota
- Assists in identifying long-term resources
- Provides referrals for long-term care

The EAP Offers Support for Many Issues

- Relationships
- Work-related concerns
- Family issues
- Stress
- Depression
- Anxiety
- Financial problems
- Loss and grief
- Substance abuse
- Other personal concerns

The EAP Is Here to Help You

"I made it through a rough time as a result of my counselor's help."

"I was able to get in right away, so I could deal with my issues right away."

"There was no judgement with calling."

"My request for help was immediately addressed. I felt listened to and valued as a person."

"I am grateful for this program."

What the EAP Is Not

• An insurance program • Part of an employee's health plan • A long-term counseling alternative

Who Can Use the EAP?

EMPLOYEES AND THEIR DEPENDENTS

As a full- or part-time employee of an MCIT public entity member, you, your spouse and your dependents* are eligible for assistance through the MCIT EAP at any time. Employees are encouraged to contact the EAP for support with managing personal or professional concerns.

*Dependents may include spouse, domestic partner, children, children who live with the other parent, children who attend college/post-secondary school, foster children, and anyone for whom you are the legal guardian.

SUPERVISORS

Department heads, supervisors and managers may use the EAP services for:

• Consultation regarding work-related situations • Supervisor coaching • Advice to help employees

Phone consultation and coaching for supervisors are available 24 hours a day, every day.

24-hour Crisis Line for Emergencies

A confidential crisis line is available by dialing the main number at **1.800.550.6248**.

Minnesota Counties Intergovernmental Trust (MCIT) has partnered with Sand Creek to provide professional counseling services to MCIT member employees like you. Sand Creek is a behavioral health care corporation based in Stillwater, Minn., and is an AllOne Health company.

For consultation or counseling services: CALL 1.800.550.6248 ONLINE at *SandCreekEAP.com*

MCIT

Employee Assistance Program Provided By

Minnesota Counties Intergovernmental Trust

For more information about the EAP program (not for counseling services):
CALL 1.866.547.6516 VISIT MCIT.org

10 LITTLE-KNOWN BUT POWERFUL FEATURES OF THE EAP

Date: August 2017

Besides the commonly understood services of the Employee Assistance Program (EAP), such as counseling for relationships, depression and anxiety, the EAP can support members' employees and officials with many other personal and workplace concerns. Here are the top 10 little-known but powerful features of the EAP:

1. **Parent coaching:** Strategies to manage a variety of parenting challenges.
2. **Elder care and child care referrals:** Array of information about child care searches, schools and special needs care; and information for elder care lifestyle options.
3. **Financial counseling:** Focuses on the individual's life situation and developing an action plan that is practical, attainable and in the best interest of the person and his or her family.
4. **Legal concerns:** Access to a single no-cost 30-minute consultation with an attorney for a variety of needs, such as family, criminal, business and civil/consumer matters.
5. **Employee's dependents are eligible for service:** This may include spouse, domestic partner, children, children who live with the other parent, children who attend college/post-secondary school, foster children and anyone for whom the employee is the legal guardian.
6. **Coaching and consultation for managers/supervisors:** Assistance over the phone for challenges related to supervision of other employees and workplace concerns.
7. **In-the-moment support:** Counselors are available 24/7 for consultation with an individual to address any concerns or questions that are causing distress at that time.
8. **Choice of where and how to work with counselors:** Counselors are available at hundreds of locations across the state, and individuals choose which provider they want to use. Counseling over the phone is also an option.
9. **Contact EAP online:** Individuals can complete an online intake form for the initial connection with the EAP provider, Sand Creek, through its website at SandCreekEAP.com.
10. **Specialized support:** The EAP matches individuals with counselors who are specifically qualified to assist with their circumstances, for example, deputies may be paired with counselors who have a law enforcement background.

Learn More

For more information about the Employee Assistance Program, members should visit MCIT.org/employee-assistance-program/ or contact MCIT Deputy Director Steve Nelson at snelson@mcit.org or 1.866.547.6516, ext. 6411.

Additional resources for individuals and supervisors, such as legal and financial forms and tools, videos for orientation to the EAP, frequently asked questions and newsletters are available through Sand Creek's website at SandCreekEAP.com.

HEALTH SAVINGS ACCOUNT (HSA)

Benton County offers a health savings account (HSA) paired alongside the qualified high deductible health plan (HDHP) with BCBS. If you participate in the HSA qualified plan you can set aside money in a health savings account (HSA) before taxes are deducted to pay for eligible medical, dental and vision expenses.

What is the Benefit?

A Health Savings Account (HSA) is an account that you and your employer can put money into to save for future medical expenses. Contributions are subject to IRS maximum guidelines (see below). There are certain advantages to putting money into these accounts, including favorable tax treatment.

Administrator:

- Wex

Plan Year:

- January 1, 2025 through December 31, 2025
  - Medical Expenses must be incurred after the date the HSA is established to be eligible for reimbursement through the HSA

Eligibility:

- Full-Time employees working at least 30 hours per week or more
- New Hires are eligible on the 1st of the month following Date of Hire.

Participation:

You are a participant if:

- You are an eligible employee;
- Are enrolled in Benton County's HSA High Deductible Health Plan;
- Are not covered under another medical plan such as Medicare, Tricare or a spouse's medical plan (not an HDHP) which provides similar first-dollar coverage; and
- Cannot be claimed as a dependent on another person's tax return.

IMPORTANT!

If you participate in a HSA You **must** keep your receipts and any associated documentation e.g. Prescriptions and medical Explanation of Benefits (EOB) with your personal tax records to prove the HSA funds were used for qualified healthcare expenses.

Whose Medical Expenses can you use your HSA funds on?

Generally your:

- Legally married spouse. Domestic partners are not covered under the tax code.
- A person you can claim as a dependent on his or her federal income tax return (or whom you would be able to claim but for income limitations that apply to income tax dependency status) such as:
  - Permanently and totally disabled dependent of any age.
  - Dependent under the age of 19 at the end of calendar year or a full-time student under the age of 24 at the end of the calendar year who also:
    - Lived with you more than ½ the calendar year, and
    - Didn't provide over ½ his/her own support in the calendar year, and
    - Didn't file a joint tax return, other than to claim a refund
- Qualifying relative. See IRS Publication 502 for more information.

When can you begin contributing?

You may begin funding your HSA when your medical HDHP benefits begin.

You are able to contribute as little or as much (up to IRS limit) as you wish out of each paycheck and this election may be changed at any time throughout the year.

When can you not contribute?

If you terminate HDHP medical plan coverage (or employment) with Benton County, you may no longer contribute to your HSA through Benton County payroll deduction.

Benton County contributions will end the date you lose eligibility.

You own the HSA so your balance can be carried over year after year and the funds you and Benton County contributed always belong to you.

Employer HSA Contribution Funding:

See **page 8** in this Benefit Guide.

The monthly employer contribution will be deposited with the 1st payroll of each month.

Health Savings Account

Why should I choose a health savings account (HSA)?

An HSA is a benefit that allows you to choose how much of your paycheck you'd like to set aside, before taxes are taken out, for healthcare expenses or use as a retirement savings tool. This plan offers tax savings that a 401(k) and IRA don't, making it a powerful option for diversifying your retirement portfolio.

It's yours
Think of your HSA as a personal savings account. Any unspent money in your HSA remains yours, allowing you to grow your balance over time. When you reach age 65, you can withdraw money (without penalty) and use it for anything, including non-healthcare expenses.

Flexibility
Save for a rainy day. Invest for your future retirement. Or spend your funds on qualified expenses, penalty free.

Easy to use
Swipe your benefits debit card at the point of purchase. There is no requirement to verify any of your purchases. We recommend keeping any receipts in case of an IRS audit.

Smart savings
The HSA's unique, triple-tax savings means the money you contribute, earnings from investments and withdrawals for eligible expenses are all tax-free, making it a savvy savings and retirement tool.

Investment options
You can invest your HSA funds in an interest-bearing account or our standard mutual fund lineup. Savvy investors may opt for a Health Savings Brokerage Account powered by Charles Schwab, giving you access to more than 8,500 mutual funds, stocks and bonds.

Can I enroll?

You must be enrolled in a high-deductible health plan (HDHP) in order to enroll in the HSA. You're not eligible for an HSA if:

- You're claimed as a dependent on someone else's taxes.
- You're covered by another plan that conflicts with the HDHP, such as Medicare, a medical flexible spending account (FSA) or select health reimbursement arrangements (HRAs).
- You or your spouse are contributing to a medical FSA.

What does it cover?

There are thousands of eligible items. The list includes but is not limited to:

- Copays, coinsurance, insurance premiums
- Doctor visits and surgeries
- Over-the-counter medications (first aid, allergy, asthma, cold/flu, heartburn, etc.)
- Prescription drugs
- Birthing and lamaze classes
- Dental and orthodontia
- Vision expenses, such as frames, contacts, prescription sunglasses, etc.

View our searchable list of eligible expenses at **www.wexinc.com/insights/benefits-toolkit/eligible-expenses/**

My HSA Planner

Why should I get a HSA (video)

Health Savings Account

Contribution Limits & IRS Regulations

The IRS sets the maximum dollar amount you can elect and contribute to a health savings account (HSA). The 2025 annual contribution limit is:

Single coverage - $4,300

Family coverage - $8,550

Please note: If you're 55 years of age or older, you are eligible to make an annual catch-up contribution, which lets you contribute an additional $1,000 on top of the above annual contribution limits. To determine your contribution, we recommend setting a goal on what you plan to use your HSA for. Keep in mind you're not locked in to that decision and can change your contribution amount at any time.

Spend on healthcare expenses
Review how much you spent last year on eligible healthcare expenses to determine your election.

Save for future healthcare expenses
How much is your high-deductible health plan (HDHP) deductible? That would be a great place to start!

Invest for retirement
Determine how much retirement-planning money you can set aside from your paycheck, pre-tax. Set your contribution and forget it, just like you would with a 401(k), Roth IRA, etc.

Hybrid
Elect and save enough money to cover your HDHP deductible, should you need it, by setting your investment threshold to mirror your deductible amount. Invest any contributions above to build your retirement nest egg.

Save on taxes 3 ways
The HSA is unique because it allows you to save on taxes in three ways. The money you contribute, your earnings from investments and withdrawals for eligible expenses are all tax-free, making it a powerful savings and retirement tool.

Fund availability and changing your election
HSA funds are available to spend, save or invest after they've been deducted from your paycheck and contributed to your HSA. You can adjust your payroll deductions or contributions at any time, no questions asked.

Privately owned savings
The HSA is your privately owned savings account. Funds roll over year to year. And if you change employers, your HSA stays with you. There is also no requirement to submit receipts or substantiation for your qualified purchases.

HSA Open Enrollment (video)

VEBA

What is the Benefit?

A Volunteer Employee Benefit Association account (VEBA) is a tax-free health care savings plan funded entirely by your employer. As soon as your employer contributes to your VEBA account, the money belongs to you. You pay no taxes on the balance, the interest earned, or on withdrawals.

Administrator:

- Wex

Plan Year:

- January 1, 2025 through December 31, 2025
  - Medical Expenses must be incurred after the date the VEBA is established to be eligible for reimbursement through the VEBA.

Eligibility:

- Full-Time employees working at least 30 hours per week or more
- New Hires are eligible on the 1st of the month following Date of Hire.

Participation:

You are a participant if:

- You are an eligible employee;
- Are enrolled in Benton County's VEBA Health Plan.

You cannot participate in a VEBA and remain eligible to participate in a Health Savings Account (HSA). If you elect to participate in an HSA after opening a VEBA, your VEBA will reimburse only the following HSA-compatible expenses: vision and dental, preventive care, post-deductible medical, post-retirement medical.

Whose Medical Expenses can you use your VEBA funds on?

Generally your:

- Legally married spouse. Domestic partners are not covered under the tax code.
- A person you can claim as a dependent on his or her federal income tax return (or whom you would be able to claim but for income limitations that apply to income tax dependency status) such as:
  - Permanently and totally disabled dependent of any age.
  - Dependent under the age of 19 at the end of calendar year or a full-time student under the age of 24 at the end of the calendar year who also:
    - Lived with you more than ½ the calendar year, and
    - Didn't provide over ½ his/her own support in the calendar year, and
    - Didn't file a joint tax return, other than to claim a refund
- Qualifying relative. See IRS Publication 502 for more information.

Ineligible expenses

You can't use VEBA funds to pay for the following:

- Health insurance premiums while working for Benton County
- Expenses that aren't IRS-qualified medical expenses

Employer VEBA Contribution Funding:

See **page 8** in this Benefit Guide.

The monthly employer contribution will be deposited with the 1st payroll of each month.

FLEXIBLE SPENDING ACCOUNT (FSA)

What is the Benefit?

A Flexible Spending Account (FSA) allows you to pay for a variety of out-of-pocket health care, dependent care and/or work-related transportation expenses with pre-tax dollars. You can save approximately 25% of each dollar spent on these expenses when you participate in a FSA.

Administrator:

- Wex

Plan Year:

- January 1, 2025 through December 31, 2025
  - Eligible expenses must be incurred within the Plan Year. **Expenses cannot be reimbursed until the service has been incurred per IRS rules.**

Accounts Offered

- Health Care FSA (medical, dental, vision expenses)
- Limited Purpose Health Care FSA (dental and vision expenses). This is account is available if you have a Health Savings Account and eligible expenses are limited to dental and vision only. This account is SEPARATE from your HSA.
- Dependent Care FSA (dependent care)

Eligibility:

- Full-Time employees working at least 35 hours per week or more
- New Hires are eligible on the 1st of the month following Date of Hire.

Who is Covered?

- Expenses for yourself and your eligible dependents can be reimbursed through an FSA, including your current legal spouse and children up to age 26 regardless of tax qualified status.
- For child day care, you are able to cover eligible dependents in the Dependent Care FSA up to age 13.

If you are eligible, you may choose to participate in a Health Care **or** Limited Purpose FSA and/or the Dependent Care FSA. Please be advised that they are separate accounts. Money cannot be transferred between accounts.

If you do not use the money you contributed it will not be refunded to you or carried forward to a future plan year.

This is the "use-it-or-lose-it" rule.

You should contribute the amount of money you expect to pay out of pocket for eligible expenses for the plan year.

There are three types of FSA's offered for dates of service during the **current** plan year:

Health Care Flexible Spending Account

(For those who do NOT have an HSA)

- allows you to set aside pre-tax dollars from your paycheck to cover eligible health care expenses that are incurred and not reimbursed by you and your dependent's medical, dental or vision insurance. To take advantage of the tax savings from a FSA, you **may not** be enrolled in a High Deductible Health Plan (HDHP) and contributing to an HSA.

Limited Purpose Flexible Spending Account

(For those who have an HSA)

- allows you to set aside pre-tax dollars from your paycheck to cover eligible dental and vision expenses. This plan is set up specifically for you if you are enrolled in a HDHP Plan and contributing to a Health Savings Account (HSA). This account is SEPARATE from the Health Savings Account.

Dependent Care Flexible Spending Account

- allows you to set aside pre-tax dollars from your paycheck to cover eligible dependent care (daycare) expenses incurred. This option is available to all eligible employees regardless of what type of plan they are covered under.

Claims Run-Out

- You have until the last day of March following the end of the plan year to file claims for expenses incurred during the plan year.

How Much Can & Should You Contribute?

The 2025 Annual limits on the amount you can contribute to your Flexible Spending Accounts are:

- Health Care & Limited Purpose FSA– A minimum of $27.00 to a maximum of $3,300 per calendar year per household.
- Dependent Care Account Limits – A minimum of $27.00 to a maximum of $5,000 if you are single or if you and your spouse file a joint tax return (or $2,500 if you and your spouse file separate tax returns)) per calendar year.

Obtain a complete list of eligible and ineligible expenses for FSAs by accessing www.irs.gov. Under "Search Forms and Publications," enter "502" for the health care plan and "503" for the dependent care plan.

Combination FSA

Why should I choose a combination FSA?

A combination flexible spending account is a benefit that allows you to choose how much of your paycheck you'd like to set aside, before taxes are taken out, for qualified dental, vision and preventative care expenses. Once you reach the IRS statutory deductible for the year, your combination FSA can also be used for any eligible healthcare and prescription costs.

Funds on Day 1

Buy those eyeglasses or finally get those braces. All of your FSA funds are available to spend right away. Use your benefits debit card at the point of purchase.

Discount

Think of it as a discount on healthcare expenses at stores such as Amazon, Target, CVS, Walmart, Walgreens and more. Dollars you contribute are taken out of your paycheck before tax, which means a $100 purchase would actually cost you over $130 without a combination FSA.*

Plan ahead

Think about the money you spent on healthcare expenses last year. Plan ahead and set those funds aside in a combination FSA and save 30%.*

*Based on a 30% tax bracket.

What does it cover before I meet my deductible?

Procedures and products deemed necessary by the IRS include but are not limited to:

- Prescription sunglasses
- Contact lenses
- Orthodontia
- Root canals/fillings

What does it cover after I meet my deductible?

All of the above, plus IRS-approved healthcare expenses, which include:

- Emergency room visits and ambulance expenses
- First aid kits and supplies
- Chiropractor treatments
- Copays

Can I enroll?

The combination FSA pairs nicely with a health savings account (HSA). However, it cannot be paired with a medical FSA. Pairing these plans allows you to spend your combination FSA dollars on eligible expenses while saving or investing your HSA dollars.

Dependent Care FSA

Why should I choose a dependent care FSA?

A dependent care FSA allows you to put aside a portion of your paycheck before taxes for eligible dependent care expenses each year.

Save money
The dependent care FSA lets you pay for eligible dependent care expenses while you reap the benefits of additional tax savings. You're spending the money either way. This way, eligible childcare and other dependent care costs are a little less.

Save strategically
Submit all of your dependent care expenses at the end of the plan year for one lump sum reimbursement to give yourself a hard-earned "bonus".

Fast Fact

For recurring costs, submit our Recurring Dependent Care Form. It makes claim filing simple because you only need to submit one form once in order to get reimbursed each pay period. You can find the form on the back of this handout.

What does it cover?

The list includes, but is not limited to, eligible:

- Childcare center, babysitter, nanny (birth through age 12)
- Summer day camp
- Before- or after-school care
- Disabled dependent and/or spouse care
- Elder care

DCA Open Enrollment (video)

View our interactive eligible expense list at **www.wexinc.com/insights/benefits-toolkit/eligible-expenses/**

Can I enroll?

You are eligible if you and/or your spouse (if applicable) are gainfully employed, looking for work, or are attending school on a full-time basis.

www.wexinc.com
866-451-3399 866-451-3245
PO Box 2926 Fargo, ND 58108-2926
forms@wexhealth.com

Recurring Dependent Care Request Form

This form is to be completed each plan year and as changes occur when you want to receive recurring reimbursement of dependent care expenses. Documentation must be retained for your records and provided to WEX when requested to do so (if a receipt is unavailable, a signature from the provider is sufficient). If any information on this request form changes during the plan year, you must submit an updated Recurring Dependent Care Request Form.

* = Required Fields

Step 1: Participant information

*Participant Name (First, MI, Last)

*Social Security Number - -

*Employer Name (Do not abbreviate)

Employee ID

Updates or changes to your information can be made by logging into your account at **www.wexinc.com**.

Step 2: Recurring dependent care FSA information

*Please select only one:

Start Recurring Dependent Care FSA: Please start my recurring reimbursement with the information provided in Step 3.

Change Recurring Dependent Care FSA Information: Please update my recurring reimbursement with the information provided in Step 3 as of the Effective Date listed on the right.

Effective Date (mm/dd/yyyy)

Stop Recurring Dependent Care FSA: Please stop my recurring reimbursement for the information provided in Step 3 as of the Effective Date listed on the right.

Effective Date (mm/dd/yyyy)

Step 3: Dependent care provider information and signature (to be completed by the provider)

I certify the information provided below is accurate. I understand the purpose of my signature on this form is to substantiate the name of the dependent care provider, the dates of service care is being provided and the dollar amount of the services. I agree to provide the necessary receipts for documenting the participant's incurred dependent care expenses.

*Dependent(s) Name	*Start Date of Service Must be within current plan year (mm/dd/yyyy)	*End Date of Service Must be within current plan year (mm/dd/yyyy)	*Provider's Signature	*Cost Per Week	*Total Cost

Step 4: Participant certification

To the best of my knowledge, the provided information is complete and accurate. By submitting this, I acknowledge my child is under the age of 13, the services are eligible dependent care expenses as defined by the IRS, that I have not been previously reimbursed for these expenses and that I will not seek reimbursement from any other source. I understand that WEX, including its agents and employees, will not be held liable if I submit ineligible expenses for reimbursement. I have obtained or made reasonable efforts to obtain the provider's Tax ID (TIN) and I will include the TIN on IRS Form 2441, which I must attach to my federal income tax return. If there are any changes in the provided information, I understand it is my responsibility to notify WEX. I understand that WEX may require me to submit any additional documentation, receipts and an updated request form at any time. I should retain a copy of all submitted documentation in the event of an IRS audit. I confirm my payroll deductions are less than my daycare costs per week so recurring reimbursements will occur when payroll deductions post to my Dependent Care FSA. By submitting this form I certify the above.

Medical FSA and Dependent Care FSA

Contribution limits & IRS regulations

The IRS sets the maximum dollar amount you can elect and contribute to a medical flexible spending account (medical FSA) and dependent care FSA. The FSA annual contribution limit is:

Medical FSA - $3,300

Dependent Care FSA - $5,000 per family or $2,500 if filing separately

Medical FSA

Once you elect, all of your medical FSA dollars are available for you to use the very first day of the plan year. For example, if you elect to contribute $1,200 to your medical FSA, your contributions will be deducted evenly across all of your paychecks for the year, but you have access to all $1,200 on Day 1! You can use your funds for expenses incurred by you, your spouse or eligible dependents.

Dependent care FSA

The dependent care FSA allows you to use the funds in your account as you contribute to the dependent care FSA from your paycheck. After each payroll contribution has been made, those funds are applied to your account and available for reimbursement. This is different from a medical FSA because you cannot use all of the funds Day 1.

Use-or-lose

Don't forget to spend your FSA dollars. If you have not used all of your FSA dollars before the end of the plan year, you will forfeit any money left in your account. (Check with your employer to confirm how many days you have to submit claims for reimbursement after the plan year ends.)

Changing your FSA election

During open enrollment, you can elect an FSA and determine how much you want to contribute. In order to make changes after open enrollment, you need to experience a qualifying life event.

Qualifying life events for any FSA:

- Change in marital status
- Change in the number of dependents
- Increase due to birth, adoption or marriage
- Decrease due to death, divorce or loss of eligibility
- Gain or loss of eligibility due to a change in participant, spouse or dependent employment status

Additional dependent care FSA qualifying life events include:

Change in daycare providers

- Child turning age 13
- Increase or decrease in the cost of qualifying day care expenses
- Judgement, decree or order requiring a change in coverage

If you experience a qualifying life event, contact your employer to make changes to your election.

DC FSA (Video)

What is FSA (Video)

DENTAL INSURANCE

Taking care of your oral health is not a luxury; it is necessary for optimal long-term health. With a focus on prevention, early diagnosis and treatment, dental coverage can greatly reduce the cost of restorative and emergency procedures.

Preventive services at in-network providers are generally covered at no cost to you and include routine exams and cleanings. You pay a small deductible and coinsurance for basic and major services.

You may enroll yourself and your eligible dependents — or you may waive dental coverage. You do not have to be enrolled in medical coverage to elect a dental plan.

Benton County offers dental coverage through Guardian. For information on finding a dental provider, visit www.guardianlife.com and click on Find a Dentist.

The cost of your dental plan is included in your monthly medical premiums.

Before You Enroll

Consider this:

1. Most in-network preventive cleanings and exams are covered at 100%.
2. You may receive dental care in- or out-of-network. However, when you go out of network, the provider can charge more and the plan will only reimburse up to the reasonable and customary rates.

DENTAL INSURANCE

The table below summarizes the key features of the Guardian dental insurance plan. Please refer to the official plan documents for additional information on coverage and exclusions.

	Dental Plan	
	DentalGuard Preferred	
	In-Network	Out-of-Network
Calendar Year Deductible		
Individual	$50	$50
Family	$150	$150
Annual Plan Maximum		
Per Individual	$1,200 plus max rollover	
Maximum Rollover		
Threshold Rollover Amount Rollover Bonus Amount Account Limit	$600 $300 $400 $1,200	
	You pay	
Preventive Care		
Exams, Cleanings, X-rays, Fluoride Treatments	0%	0%
Basic Services		
Fillings, Space Maintainers, Sealants, Extractions, Emergency Exams	20%	20%
Major Services		
Crowns, Inlays/Outlays, Dentures and Bridgework, Repairs, Oral Surgery, Endodontics, Periodontics, Emergency Exams	50%	50%

Guardian

Benton County
ALL ELIGIBLE EMPLOYEES
Group Number: 00071144

Customer Service (888) 600-1600
Monday to Friday | 8am to 8:30pm ET

Welcome to
Workplace benefits

Everyone deserves a Guardian

Every day, Guardian gives 26 million Americans the security they deserve through our insurance and wealth management products and services.

We've partnered with your organization to offer you a range of employee benefits. Inside this pack, you'll find the plans your employer thinks you might benefit from.

Your coverage options

Dental insurance	Taking care of teeth and overall health

Know your benefits

Your benefits support your physical and financial wellbeing, to help keep you and your loved ones protected.

With Guardian, you're in good hands. We've been delivering on our promises for over 150 years, and we're looking forward to doing the same for you too.

1. Read through this information.
2. Find out more about your benefits.
3. Talk to your employer if you need help or have any questions.

This document is a summary of the major features of the insurance coverage that's been agreed to with your employer – it isn't your contract.

Guardian®

Watch our video
Learn how dental insurance can protect your long-term health.

Dental insurance

Taking care of your teeth is about more than just covering cavities and cleanings. It also means accounting for more expensive dental work, and your overall health.

With dental insurance, routine preventive care can lead to better overall health. And you'll be able to save money if any extensive dental work is required.

Who is it for?

Everyone should have access to great dental coverage, which is why we offer comprehensive plans that are available through employers as part of your benefit offerings.

What does it cover?

Dental insurance helps to protect your overall oral care. That includes services like preventive cleanings, x-rays, restorative services like fillings, and other more serious forms of oral surgery if you ever need them.

Why should I consider it?

Poor oral health isn't just aesthetic, it's also been linked to conditions including diabetes, heart disease, and strokes. So, while brushing and flossing every day can help keep your teeth clean, nothing should replace regular visits to the dentist.

You will receive these benefits if you meet the conditions listed in the policy.

Staying healthy

Joe visits his dentist for a routine dental cleaning, to take care of his teeth as well as his overall health.

Oral health is about more than just teeth and gums. It's also essential for a range of other health and wellbeing reasons:

Cardiovascular disease: Some research suggests that heart disease, clogged arteries, and strokes may be linked to inflammation and infections from oral bacteria.

Osteoporosis: Weak and brittle bones may be linked to tooth loss.

Diabetes: Research shows that people with gum disease find it more difficult to control their blood sugar levels.

Alzheimer's disease: Worsening oral health is seen as Alzheimer's disease progresses.

All information contained here is from the Mayo Clinic, Oral Health: A Window to Your Overall Health, www.mayoclinic.com. 2021.

Benton County
ALL ELIGIBLE EMPLOYEES
2023-157076 (07/25)

Kit created 09/27/2024
Group number 00071144

Guardian®

Your dental coverage

A Sample of Services Covered by Your Plan:

Your Network is DentalGuard Preferred Network

		PPO *Plan pays (on average)*	
		Tier 1	Tier 2
Preventive Care	Cleaning (prophylaxis)	100%	100%
	Frequency:	Once Every 6 Months (applies to all levels)	
	Fluoride Treatments	100%	100%
	Limits:	Under Age 14 (applies to all levels)	
	Oral Exams	100%	100%
	Sealants (per tooth)	100%	100%
	X-rays	100%	100%
Basic Care	Fillings‡	80%	80%
	Periodontal Maintenance	80%	80%
	Frequency:	Once Every 3 Months (applies to all levels)	
	Simple Extractions	80%	80%
Major Care	Anesthesia*	50%	50%
	Bridges and Dentures	50%	50%
	Dental Implants	50%	50%
	Inlays, Onlays, Veneers**	50%	50%
	Perio Surgery	50%	50%
	Repair & Maintenance of Crowns, Bridges & Dentures	50%	50%
	Root Canal	50%	50%
	Scaling & Root Planing (per quadrant)	50%	50%
	Single Crowns	50%	50%
	Surgical Extractions	50%	50%

Guardian's Preferred Provider Organization consists of Dentists in the DentalGuard Preferred ("DGP") network. These tiers represent specific benefit levels as described in Your Schedule of Benefits. Network access varies by geographic location and zip code. Please visit www.Guardianlife.com to confirm your Dentist's tiered participation.

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. **For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filing material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age limit set by your plan; If full-time status is required by your plan in order to remain insured after a certain age; then orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for "Adults and Child(ren)" this limitation does not apply. *General Anesthesia – restrictions apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings.

Guardian

Your dental coverage

Manage Your Benefits:

Go to www.Guardianlife.com to access secure information about your Guardian benefits including access to an image of your ID Card. Your on-line account will be set up within 30 days after your plan effective date.

Find A Dentist:

Visit www.Guardianlife.com
Click on "Find A Provider"; You will need to know your plan, which can be found on the first page of your dental benefit summary.

Need Assistance?

Call the Guardian Helpline (888) 600-1600, weekdays, 8:00 AM to 8:30 PM, EST. Refer to your member ID (social security number) and your plan number: 00071144

Please call the Guardian Helpline if you need to use your benefits within 30 days of plan effective date. Please note, self-serve options over the phone or online at Guardian Anytime are not available until the case is fully implemented, please wait to speak to a live agent when calling the Guardian Helpline.

EXCLUSIONS AND LIMITATIONS

Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred Network PPO plans: This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury. Deductibles apply. The plan does not pay for: oral hygiene services (except as covered under preventive services), orthodontia (unless expressly provided for), cosmetic or experimental treatments (unless they are expressly provided for), any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment. The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic, and prosthodontic services. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract # DG7-P et al.

BENTON COUNTY OPTIONAL EMPLOYEE PROGRAMS (through Payroll Deduction)

SEE EMPLOYEE INTRANET FOR MORE BENEFIT INFORMATION (http://10.0.0.29/)

BlueCross BlueShield of MN

Customer Service
1-800-382-2000
651-662-8000
www.bluecrossmn.com

- $3,000/$6,000 Deductible Plan (with VEBA)
- $3,200/$6,000 Deductible Plan (with HSA)

Aflac Insurance

Corey Werk 218-316-0840 (Cell)

korey@yourmassivelegacy.com

- Cancer Coverage
- Hospital Intensive Coverage
- Long Term Care
- Home Health Care
- Eye Care Plan
- Short Term Disability
- Accident/Sickness Insurance
- Flexible Benefit Plan

NCPERS Voluntary Life Insurance

(800) 524-0542

- Optional Group Life Insurance (includes coverage for spouse and children)
- Accidental Death & Dismemberment Insurance

EMPLOYEE RETIREMENT & INVESTMENT SERVICES:

Nationwide Retirement Solutions

Steve Mahn (720) 749-9101 (Cell)

1-877-6773678

MAHNS1@nationwide.com

- Deferred Compensation Program

Minnesota State Retirement System

Bjorn Anderson

(320) 212-0600 or (800) 657-5757

Bjorn.Anderson@msrs.us

- Deferred Compensation Program

First Stop Health

Customer Service
1-888-691-7867
www.fshealth.com

- Telemedicine
- Virtual Counseling

Wex

Customer Service
1-866-451-3399
customerservice@wexhealth.com
www.wexinc.com

- Flexible Benefit Plan (FSA) (Pre-Tax Benefits: Medical Reimb., Dependent Care Reimb., Health Insurance)
- VEBA/HSA administration

Minnesota Mutual

(800) 392-7295 (Ochs Inc.)

- Optional Group Life Insurance (includes coverage for spouse and children)
- Long Term Disability Insurance

PENSION PLAN

Public Employees Retirement Association (PERA)
The following contributions are mandated by law:

	Coordinated Plan	Correctional Plan	Police & Fire Plan
County Contribution:	7.5%	8.75%	17.7%
Employee Contribution:	6.5%	5.83%	11.8%

Guardian Dental Insurance

Group Number: 0007114
Customer Service: (888) 600-1600
Monday to Friday 8am to 8:30pm ET

Group Life Insurance Program

Your Employer provides benefit eligible employees Term Life and Accidental Death & Dismemberment (AD&D) Insurance through Securian Financial – Administered by Ochs

LIFE and AD&D INSURANCE

Protect yourself and your family from the unexpected loss of life and income during working years. Life Insurance provides a financial benefit to beneficiaries upon death; AD&D Insurance provides additional financial protection if the insured's death or dismemberment is due to a covered accident, whether it occurs at work or elsewhere.

HOW MUCH LIFE INSURANCE DO YOU NEED?

Check out the life insurance calculator at **LifeBenefits.com/Insuranceneeds**.

Insurance helps cover

- Funeral/burial costs
- Medical bills
- Taxes & living expenses (i.e. mortgage, childcare)

Automatically Enrolled Coverage - employer paid			
Employee Basic Term Life and AD&D	Enrolled	**Amount varies -** depending on job classification*	• Includes a matching AD&D benefit
Dependent Life Package	Enrolled	**$1,000** spouse and **$1,000** children	• Insures your spouse and all dependent children - live birth to age 26
Elect Supplemental Coverage - employee paid			
Employee Term Life and AD&D	Elect	up to **$500,000*** maximum	• Elect in $5,000 increments • Includes a matching AD&D benefit
Spouse Term Life and AD&D	Elect	up to **$150,000** maximum	• Elect in $5,000 increments • Includes a matching AD&D benefit
Child Term Life	Elect	**$10,000** or **$15,000** each child	• One premium insures all eligible children from live birth to age 26

If your spouse or child is eligible for employee coverage, they cannot be covered as a dependent. Only one employee may cover a dependent child. It is the employee's responsibility to notify their employer when dependents are no longer eligible for coverage.

*Coverage reduces to 65% beginning at age 65 (see certificate for details).

MONTHLY COST

Employee or Spouse Supplemental Term Life and AD&D

See rate grid for easy cost calculation.

Age	Rate per $1,000
<25	$0.07
25-29	$0.08
30-34	$0.10
35-39	$0.11
40-44	$0.14
45-49	$0.23
50-54	$0.39
55-59	$0.63
60-64	$0.77
65-69	$1.33
70-74	$2.08
75*	$2.40

*Rates beyond age 75 are available upon request.
Rates increase with age and all rates are subject to change.

MONTHLY COST

Child Term Life

$10,000	$15,000
$1.30	$1.95

One premium insures all eligible children.

ENROLL NOW

Turn in your completed forms to your employer by the enrollment deadline. Premiums will be automatically deducted from your paycheck.

BENEFICIARY DESIGNATIONS

Naming a beneficiary is an important right of life insurance ownership; this determines who receives the death benefit. It is recommended that you review and update your elections periodically.

ADDITIONAL FEATURES

- **Waiver of Premium** - If you become totally and permanently disabled, according to the terms of your certificate, life insurance premiums may be waived.
- **Accelerated Benefit** - If an insured person is diagnosed with a terminal illness, as defined in your certificate, he/she may be eligible to request early payment of the life insurance in force.
- **Continuation** - If you are no longer eligible for coverage as an active employee, you may be eligible to continue your coverage, if elected during the limited enrollment period. Premiums may be higher than those paid by active employees. Contact your employer or Ochs for information.

NEWLY HIRED EMPLOYEES

A special guaranteed issue opportunity is available for newly hired employees during their initial 31 day enrollment period. No evidence of insurability is required for the following **guaranteed amounts:**

- **Employee** - up to **$200,000**
- **Spouse** - up to **$25,000**
- **Child** - **all coverage**

Evidence of insurability is required *for elections above the guaranteed amounts.*

ANNUAL ENROLLMENT

During your employer's designated annual enrollment period, no evidence of insurability is required for the following **guaranteed amounts:**

- **Child** - **all coverage**

Evidence of insurability is required *for all other elections.*

OTHER ENROLLMENT

If your policy or employer allows enrollment outside of their designated enrollment periods, **elections will require evidence of insurability.** *If you experience a family status change, check with your employer within 31 days to confirm guaranteed issue eligibility.*

Contact Ochs

ochs@ochsinc.com
651-665-3789 or 1-800-392-7295

Ochs, Inc.
A Securian Financial Company
400 Robert Street N, Ste. 1880, St. Paul, MN 55101

Email: ochs@ochsinc.com
Phone: 651-665-3789 • 1-800-392-7295
Web: ochsinc.com

Employee and Spouse Supplemental Term Life and AD&D Monthly Rates (based on age)

Age	< 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74*
Rate per $1,000	$0.07	$0.08	$0.10	$0.11	$0.14	$0.23	$0.39	$0.63	$0.77	$1.33	$2.08
Coverage Amount											
$5,000	0.35	0.40	0.50	0.55	0.70	1.15	1.95	3.15	3.85	6.65	10.40
$10,000	0.70	0.80	1.00	1.10	1.40	2.30	3.90	6.30	7.70	13.30	20.80
$20,000	1.40	1.60	2.00	2.20	2.80	4.60	7.80	12.60	15.40	26.60	41.60
$30,000	2.10	2.40	3.00	3.30	4.20	6.90	11.70	18.90	23.10	39.90	62.40
$40,000	2.80	3.20	4.00	4.40	5.60	9.20	15.60	25.20	30.80	53.20	83.20
$50,000	3.50	4.00	5.00	5.50	7.00	11.50	19.50	31.50	38.50	66.50	104.00
$60,000	4.20	4.80	6.00	6.60	8.40	13.80	23.40	37.80	46.20	79.80	124.80
$70,000	4.90	5.60	7.00	7.70	9.80	16.10	27.30	44.10	53.90	93.10	145.60
$80,000	5.60	6.40	8.00	8.80	11.20	18.40	31.20	50.40	61.60	106.40	166.40
$90,000	6.30	7.20	9.00	9.90	12.60	20.70	35.10	56.70	69.30	119.70	187.20
$100,000	7.00	8.00	10.00	11.00	14.00	23.00	39.00	63.00	77.00	133.00	208.00
$110,000	7.70	8.80	11.00	12.10	15.40	25.30	42.90	69.30	84.70	146.30	228.80
$120,000	8.40	9.60	12.00	13.20	16.80	27.60	46.80	75.60	92.40	159.60	249.60
$130,000	9.10	10.40	13.00	14.30	18.20	29.90	50.70	81.90	100.10	172.90	270.40
$140,000	9.80	11.20	14.00	15.40	19.60	32.20	54.60	88.20	107.80	186.20	291.20
$150,000	10.50	12.00	15.00	16.50	21.00	34.50	58.50	94.50	115.50	199.50	312.00
$160,000	11.20	12.80	16.00	17.60	22.40	36.80	62.40	100.80	123.20	212.80	332.80
$170,000	11.90	13.60	17.00	18.70	23.80	39.10	66.30	107.10	130.90	226.10	353.60
$180,000	12.60	14.40	18.00	19.80	25.20	41.40	70.20	113.40	138.60	239.40	374.40
$190,000	13.30	15.20	19.00	20.90	26.60	43.70	74.10	119.70	146.30	252.70	395.20
$200,000	14.00	16.00	20.00	22.00	28.00	46.00	78.00	126.00	154.00	266.00	416.00
$210,000	14.70	16.80	21.00	23.10	29.40	48.30	81.90	132.30	161.70	279.30	436.80
$220,000	15.40	17.60	22.00	24.20	30.80	50.60	85.80	138.60	169.40	292.60	457.60
$230,000	16.10	18.40	23.00	25.30	32.20	52.90	89.70	144.90	177.10	305.90	478.40
$240,000	16.80	19.20	24.00	26.40	33.60	55.20	93.60	151.20	184.80	319.20	499.20
$250,000	17.50	20.00	25.00	27.50	35.00	57.50	97.50	157.50	192.50	332.50	520.00
$260,000	18.20	20.80	26.00	28.60	36.40	59.80	101.40	163.80	200.20	345.80	540.80
$270,000	18.90	21.60	27.00	29.70	37.80	62.10	105.30	170.10	207.90	359.10	561.60
$280,000	19.60	22.40	28.00	30.80	39.20	64.40	109.20	176.40	215.60	372.40	582.40
$290,000	20.30	23.20	29.00	31.90	40.60	66.70	113.10	182.70	223.30	385.70	603.20
$300,000	21.00	24.00	30.00	33.00	42.00	69.00	117.00	189.00	231.00	399.00	624.00
$350,000	24.50	28.00	35.00	38.50	49.00	80.50	136.50	220.50	269.50	465.50	728.00
$400,000	28.00	32.00	40.00	44.00	56.00	92.00	156.00	252.00	308.00	532.00	832.00
$450,000	31.50	36.00	45.00	49.50	63.00	103.50	175.50	283.50	346.50	598.50	936.00
$500,000	35.00	40.00	50.00	55.00	70.00	115.00	195.00	315.00	385.00	665.00	1,040.00

**Additional rates available upon request*

Rates change according to age brackets.

Automatic access to Lifestyle Benefits

Your employer's group insurance programs help protect your financial wellness. You also have even more resources at your disposal.

Legal, financial and grief resources
from LifeWorks by Morneau Shepell

Travel assistance
from RedpointWTP LLC

Legacy planning resources
from Securian Financial

Beneficiary financial counseling
from Pricewaterhouse-Coopers LLP

There is no additional fee or enrollment for these resources. Just access them as you need them. Lifestyle Benefits are automatically available to active U.S. employees insured with Securian Financial. Your spouse and insurance-eligible children can also use these resources, even if they are not insured with us.

Legal, financial and grief resources

Whether it's creating a will or advice on a legal matter, getting a handle on your financial life, or struggling to cope with the loss of a loved one — whatever your situation — get the professional help you need.

- Comprehensive web and mobile resources
- Templates to create a will and other key legacy documents
- Access to a financial fitness assessment
- Unlimited telephone consultation with legal, financial and grief professionals
- Complimentary 30-minute face-to-face consultation with an attorney
- Discounted legal fees after your consultation

How to access:

LifeBenefits.com/Lfg

user name: *lfg*
password: *resources*

1-877-849-6034

Travel assistance

Planning to travel 100 or more miles from home? Access pre-trip planning and emergency services, including:

- Information on passport, visa, immunization requirements
- Updated currency conversion information
- Medical relocation and medical or security evacuation
- Identity theft support if your wallet or purse are lost or stolen
- Assistance replacing lost or stolen luggage or other critical items
- Repatriation of mortal remains

How to access:

LifeBenefits.com/travel

U.S./Canada:
1-855-516-5433

All other locations:
1-415-484-4677

Consider adding contact info to your phone. And you can learn more by calling Redpoint before your trip.

Legacy planning resources

Get the support you need to ensure your family's affairs are in order:

- End-of-life planning
- Creation of key directives
- Final arrangements for funeral services
- Funeral concierge service

How to access:

Securian.com/legacy

Beneficiary financial counseling

Beneficiaries will have access to professional guidance to help them make sound financial decisions regarding policy proceeds.

- Financial fitness assessment
- Financial workbooks
- Beneficiary reference guide
- Access to informational financial counseling website
- Bi-monthly newsletter
- Access to specialized resources if receiving larger benefit proceeds

How to access:

Beneficiaries receiving $25,000 or more will be invited to take advantage of this program when the life insurance claim is paid.

securian FINANCIAL™

INSURANCE
INVESTMENTS
RETIREMENT

securian.com

400 Robert Street North, St. Paul, MN 55101-2098

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Voluntary Long-Term Disability Insurance Calculation Form

You may elect units of $100, with a minimum election of $500, up to 60% of your covered monthly earnings to a maximum of $5,000 per month.

Follow the steps below to calculate your current maximum monthly benefit amount and approximate monthly premium taken through payroll deduction.

Step 1

Enter your basic monthly pay (annual pay, divided by 12), rounded to the next higher $1.00. 1._____

Step 2

Multiply Step 1 by 0.60 and enter the result (rounded to the next higher $100 increment). **Do not enter more than $5,000. This is your maximum monthly benefit amount.** 2._____

Step 3

Choose the benefit amount you wish to elect, not to exceed the amount calculated in Step 2. 3._____

Step 4

Divide amount elected in Step 3 by 100 4._____

Step 5

Multiply the amount from Step 4 by the age rate from the chart below. This is your **approximate** monthly premium for your selected benefit amount. Your rate will be reevaluated annually according to your attained age each subsequent policy anniversary. 5._____

Rates
(per $100 monthly benefit)

Your Age	Rate
Less than 25	$0.18
25 – 29	$0.18
30 – 34	$0.24
35 – 39	$0.43
40 – 44	$0.50
45 – 49	$0.76
50 – 54	$0.87
55 – 59	$0.86
60 – 64	$0.92
65 and over	$0.77

Benton County 070120

Public Employees Retirement Association of Minnesota
Public Employee Financial Protection Plan

Guaranteed coverage you can keep for life

Group Decreasing Term Life Insurance

Up to **$325,000** in total coverage for **$16** a month plus **NEW** **Student Loan Benefit**

National Conference on Public Employee Retirement Systems

1025138-00001-00

Life is filled with unexpected events

For $16 a month, you can help protect everything you've worked so hard for, even after you're gone.

Through your employer, you are automatically a member of the National Conference on Public Employee Retirement Systems (NCPERS). It's one of the largest trade associations for public sector employees, providing benefits and plans to over 21 million employees and retirees.

NCPERS Public Employee Financial Protection Plan gives your family extra financial security when they need it most: when you're no longer there to help provide for them. This coverage is guaranteed issue, which means there are no medical questions or exams. **You can never lose coverage because of a change in your age or health.** And you'll be happy to know that your coverage is issued by **The Prudential Insurance Company of America (Prudential)**, a company with over 100 years of group life insurance experience. We're pleased to offer you this opportunity. Don't miss out—enroll today.

Sincerely,

Daniel Fortuna

Daniel Fortuna
President

More coverage when you need it most

The plan is designed to pay a maximum benefit amount in your younger years, when your financial obligations may be more significant. That benefit gradually decreases as you get older, when your financial obligations may be less. And the flat rate helps ensure it's affordable coverage the whole time, with no surprise rate hikes.

AGE 50 AND UNDER

$16 a month means:
A way to supplement pension survivor benefits during the early family-building years, when your family's needs are greatest.

OVER AGE 50

$16 a month means:
Your family will have help covering essentials like funeral costs, medical bills, and credit card debt.

Exclusive member benefit—**$16/month.**

NCPERS has paid **$13 million** in benefits in 2016 and covered members and their families for 40 years.

NCPERS' Public Employee Financial Protection Plan includes:

For You: Group Decreasing Term Life

With Group Decreasing Term Life Insurance, your family can have insurance protection against the unexpected. The money can go toward paying for funeral expenses, mortgage, rent, credit card bills, college tuition, and other expenses.

For You: Accidental Death & Dismemberment (AD&D)

Your beneficiary can receive an additional benefit for loss of your life resulting from an accident. You may also be eligible for a benefit if you are in an accident which results in specific injuries. Injuries covered may include loss of sight, coma, or dismemberment of hands or feet.*

For Your Family: Spouse and Dependent Group Decreasing Term Life

At no added cost, this plan provides Dependent Group Decreasing Term Life Insurance for your spouse or domestic partner and a flat benefit for all of your dependent children. The benefit amount will be paid to you in a lump sum on an eligible dependent's death, and the benefit amount will be determined by your age at that time.

**See the Booklet-Certificate for complete plan information, including limitations and exclusions.*

A group rate that's competitive

NCPERS guarantees that every active member, regardless of age, pays $16 a month, and it will **never increase**.

Members

Dependent Group Decreasing Term Life

Member's Age at Time of Claim	Group Decreasing Term Life	Group AD&D	Total Benefit for Accidental Death	Spouse/ Domestic Partner	Child(ren)*
Less than 25	$225,000	$100,000	$325,000	$20,000	$4,000
25 to 29	$170,000	$100,000	$270,000	$20,000	$4,000
30 to 39	$100,000	$100,000	$200,000	$20,000	$4,000
40 to 44	$65,000	$100,000	$165,000	$18,000	$4,000
45 to 49	$40,000	$100,000	$140,000	$15,000	$4,000
50 to 54	$30,000	$100,000	$130,000	$10,000	$4,000
55 to 59	$18,000	$100,000	$118,000	$7,000	$4,000
60 to 64	$12,000	$100,000	$112,000	$5,000	$4,000
65 and over	$7,500	$7,500	$15,000	$4,000	$4,000

Payment Examples:

1. If an insured member age 38 dies of natural causes, the beneficiary would receive $100,000. If death is due to a covered accident, $200,000 would be payable.
2. If the spouse or domestic partner of a 42-year-old member dies, the member would receive $18,000.
3. If a dependent child less than age 26 dies, the payment to the member would be $4,000.

**Unmarried children up to age 26 are covered, including adopted children, stepchildren, and foster children who depend on you for support. Dependents in the military service are not eligible.*

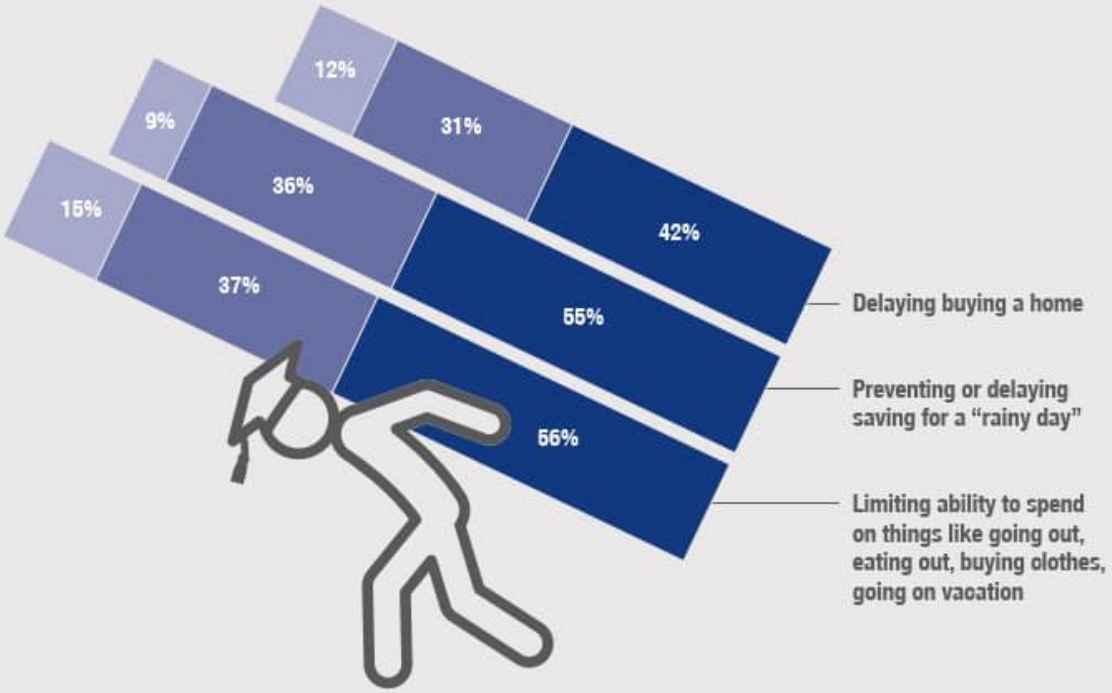
Please note: insurance coverage for a child will not end at age 26 if the child is then mentally or physically incapable of earning a living and meets the definition of Qualified Dependent.

NEW! Student Loan Protection Benefit

Included in the Group Decreasing Term Life Insurance Plan at no extra cost

Paying off student loans can be challenging enough—but when an unexpected illness or disability prevents you from earning a paycheck, things can get out of control quickly unless you have a backup plan. Ask yourself this: when you are unable to work and faced with a student loan payment in addition to countless other bills, what will you do?

The Student Loan Burden Can Result In**:



63%
OF AMERICANS LIVE PAYCHECK TO PAYCHECK**

AND

52%
OF AMERICANS HAVE LESS THAN $10,000 IN SAVINGS**

New Benefit Can Help Keep your Financial Future on Track

The Student Loan Protection benefit is included in Group Decreasing Term Life Insurance Plan at no extra cost. For members age 45 and under, Prudential will reimburse the amount of student loans you owe up to a maximum of $50,000, should you become totally disabled under the terms of the policy* and have an outstanding student loan balance.

Limited Time Offer!

Don't miss your one chance this year to get this plan.

Reply with the enclosed enrollment form today.

**Total Disability: You are "Totally Disabled" when:*
(1) You are not working at any job for wage or profit; and
(2) Due to Sickness, Injury or both, you are not able to perform for wage or profit, the material and substantial duties of any job for which you are reasonably fitted by your education, training or experience.

*** American Payroll Association, "Getting Paid in America" Survey, 2016.*

Special features

NEW! Student Loan Protection Benefit

If you are age 45 and under, approved for a waiver of premium claim due to a total disability, and have an outstanding student loan balance, Prudential will reimburse the amount of student loans that you owe up to a maximum of $50,000. We developed this benefit to help address the rising burden of student loans.

Waiver of Premium

If you are less than 60 years old and become totally disabled for at least nine months, your insurance may be continued without further premiums, as long as you furnish annual proof of your continued total disability satisfactory to Prudential.

Option to Accelerate Payment of Death Benefits*

If you are terminally ill with a life expectancy of six months or less, you may receive up to 50% of your insurance benefits—up to a maximum of $112,500 in advance. The death benefit, payable to your beneficiary, will be reduced by that amount.

Conversion of Coverage

If you cease to be a member, you can convert your insurance to a Prudential individual life policy within 31 days following termination of insurance. Dependent Spouse or Domestic Partner Group Decreasing Term Life coverage can also be converted if you cease to be a member or die.

Retirement Coverage

Coverage can be continued into retirement if you are insured as an active member and continue to receive a benefit upon retiring. Simply authorize the retirement system to deduct your contributions from your retirement check. Your premium will remain the same regardless of your age.

150,000 of your peers have coverage.

Benefits summary

- Guaranteed coverage—no medical exams or questions required
- 24/7 coverage on or off the job
- Spouse and dependent coverage included
- AD&D coverage included
- Student Loan Benefit

Enrolling is easy

Complete the enclosed enrollment and beneficiary form, go to www.ncpersvoluntarylife.com/mn, or your employer's website to obtain a printable copy of the form. Submit your completed enrollment form to your employer. Your employer will begin payroll deductions and forward your enrollment information to Member Benefits.

Questions? Contact:

Member Benefits
10739 Deerwood Park Blvd, Suite 200-B, Jacksonville, FL 32256

800-525-8056

NCPERS@memberbenefits.com

Information about when coverage begins and ends

If you enroll within 90 days of your date of employment, you will become insured on the first day of the month following your first payroll deduction. If you enroll during the open enrollment period, your coverage begins on the first day of the month following your first payroll deduction. Your member coverage will be delayed if you are not actively at work on the coverage effective date. Instead, your coverage will begin on the date you meet the actively-at-work and other insurance requirements for covered members. Dependent coverage begins when your insurance coverage becomes effective. Coverage will end if you discontinue payments, cease to be a member of the eligible classes, or if the plan is discontinued. Refer to the Booklet-Certificate for details.

*Option to Accelerate Payment of Death Benefits is a feature that is made available to group life insurance participants. It is not a health, nursing home, or long-term care insurance benefit and is not designed to eliminate the need for those types of insurance coverage. The death benefit is reduced by the amount of the accelerated death benefit paid. There is no administrative fee to accelerate benefits. Receipt of accelerated death benefits may affect eligibility for public assistance and may be taxable. The federal income tax treatment of payments made under this rider depends upon whether the insured is the recipient of the benefits and is considered terminally ill. You may wish to seek professional tax advice before exercising this option. This brochure describes the Group Insurance Plan in a general manner.

A Booklet-Certificate with complete plan information, including limitations and exclusions, will be provided when you enroll. If there is a discrepancy between this communication and the Booklet-Certificate issued by The Prudential Insurance Company of America, the Booklet-Certificate will govern.

NCPERS is a non-profit organization that provides education and support to public employee retirement systems. NCPERS has no role in the administration of the life insurance program, and the benefits are guaranteed solely by the insurance carrier. NCPERS is compensated solely for the use of its name, service marks, and mailing lists.

Plan arranged and managed by Gallagher Benefit Services, Inc., the employee benefits division of Arthur J. Gallagher & Co. Gallagher receives compensation for the marketing and services it provides, which is discussed and disclosed annually with NCPERS.

Group Decreasing Term Life Insurance, Dependent Group Decreasing Term Life Insurance, and Accidental Death & Dismemberment Insurance coverages are issued by The Prudential Insurance Company of America, a Prudential Financial company, Newark, NJ. Contract Series: 83500.

This AD&D policy provides ACCIDENT insurance only. It does NOT provide basic hospital, basic medical, or major medical insurance as defined by the New York State Department of Financial Services.

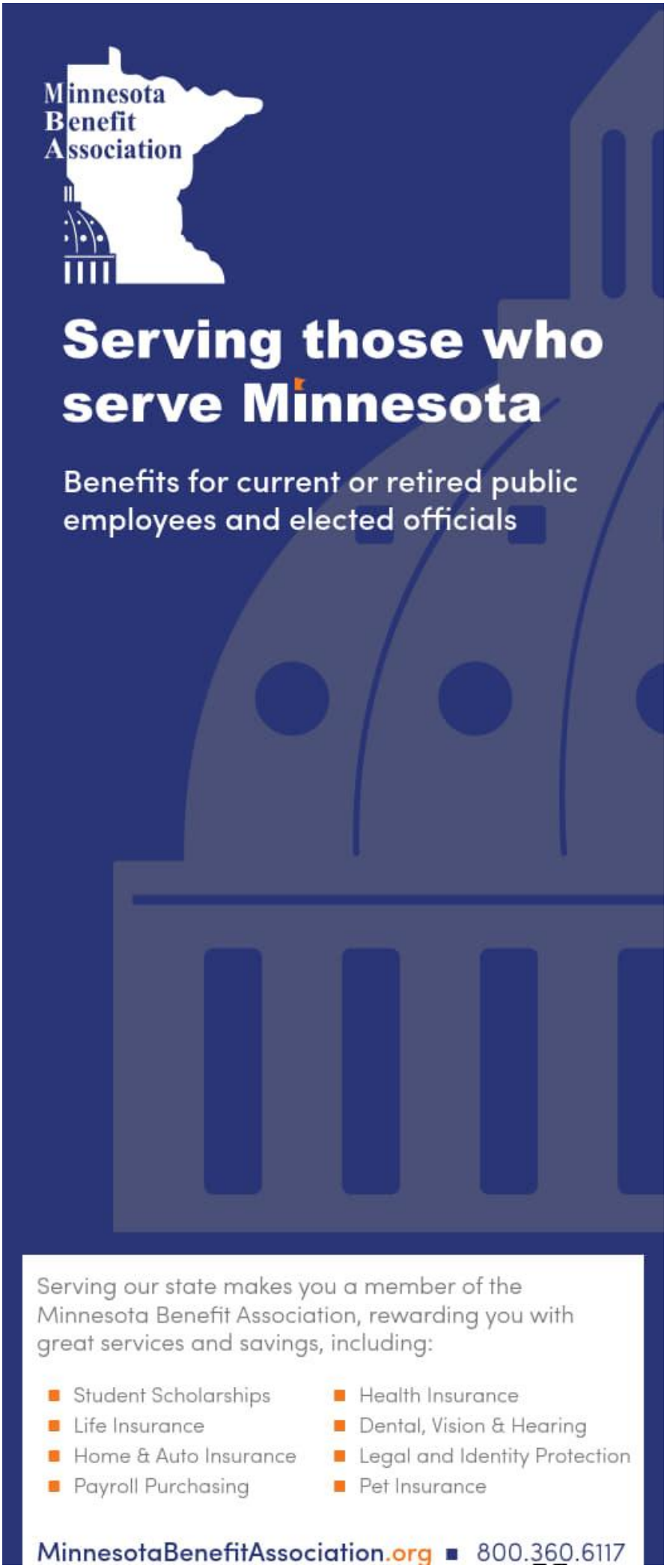
IMPORTANT NOTICE—THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.

The plan is administered by Member Benefits and Gallagher Benefit Services, Inc. who are not affiliates of Prudential.

MB | MemberBenefits

Gallagher
Insurance | Risk Management | Consulting

Prudential


Minnesota
Benefit
Association
Serving those who serve Minnesota
Benefits for current or retired public employees and elected officials
Serving our state makes you a member of the Minnesota Benefit Association, rewarding you with great services and savings, including:
Student Scholarships
Life Insurance
Home & Auto Insurance
Payroll Purchasing
Health Insurance
Dental, Vision & Hearing
Legal and Identity Protection
Pet Insurance
MinnesotaBenefitAssociation.org ■ 800.360.6117

Minnesota Benefit Association (MBA), founded in 1929, is the voluntary benefits provider of choice for Minnesota public employees.

MBA is a non-profit dedicated to providing exclusive services, benefits and scholarship programs to current or retired public employees and elected officials in the state of Minnesota.

All public sector employees and retirees in the state are automatically eligible for MBA benefits after their first 30 calendar days of full or part-time employment. Public sector includes all state, county, city, and public health employees; in addition to federal employees residing in Minnesota.

As a member, you have access to various services and benefits, including:

- Student Scholarships
- Life Insurance
- Home & Auto Insurance
- Payroll Purchasing
- Health Insurance
- Dental, Vision & Hearing
- Legal & Identity Protection
- Pet Insurance

Take advantage of your MBA benefits today.

Call us: 800.360.6117
Email us: Info@MinnesotaBenefitAssociation.org

Register for our newsletter on our website at

MinnesotaBenefitAssociation.org

Serving those who serve Minnesota

Benton County's Health and Welfare Benefits Annual Notice Packet

For the 2025 Plan Year

Dear Valued Employee,

Enclosed is a packet of notices and disclosures that pertain to your employer-sponsored health and welfare plans, as required by federal law.

Enclosures:

- ☐ Medicare Part D Creditable Coverage Notice
- ☐ HIPAA Special Enrollment Rights Notice
- ☐ Women's Health and Cancer Rights Act (WHCRA) Notice
- ☐ Newborns' Mothers Health Protection Act (NMHPA) Notice
- ☐ HIPAA Notice of Privacy Practices
- ☐ Children's Health Insurance Program (CHIP) Notice

Should you have any questions regarding the content of the notices, please contact:

Benton County Human Resources
531 Dewey Street, PO Box 129
Foley, MN 56329
HR@co.benton.mn.us

320-968-5004

Medicare Part D
Creditable Coverage Notice

Important Notice from BlueCross BlueShield of MN
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 BlueCross BlueShield of MN (BCBS of MN) 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. **BCBS of MN has determined that the prescription drug coverage offered by Benton County 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 while enrolled in BCBS of MN coverage as an active employee, please note that your BCBS of MN coverage will be the primary payer for your prescription

drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in BCBS of MN coverage as a former employee.

You may also choose to drop your BCBS of MN coverage. If you do decide to join a Medicare drug plan and drop your current BCBS of MN coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with BCBS of MN and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information or call BCBS of MN at 866-543-5966. **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 BCBS of MN changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

Contact--Position/Office: Benton County Human Resources
Address: 531 Dewey Street, PO Box 129, Foley, MN 56329
Phone Number: 320-968-5004

HIPAA Special Enrollment Rights Notice

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

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

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

Women's Health Cancer Rights Act (WHCRA) Notice

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator listed on the first page of this packet.

Newborns' and Mothers' Health Protection Act (NMHPA) Notice

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 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).

HIPAA Notice of Privacy Practices

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

Benton County sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of Benton County, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

(1) your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by Benton County, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the Benton County HIPAA Privacy Officer:

Benton County
Benton County Human Resources
531 Dewey Street, PO Box 129
Foley, MN 56329
HR@co.benton.mn.us

320-968-5004

Effective Date

This Notice as revised is effective January 1, 2025.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment

We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment

We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations

We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates
We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law
We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety
We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors
For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation
If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans
If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation
We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks
We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities
We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes
If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement
We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors
We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities
We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates
If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research

We may disclose your protected health information to researchers when:

(1) the individual identifiers have been removed; or
(2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits
We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You
When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach.
We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

Personal Representatives
We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

(1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
(2) treating such person as your personal representative could endanger you; or
(3) in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members
With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations
Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising

or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy
You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend
If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

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

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures
You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period ABC Company has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will

notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions
You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see Your Rights Under HIPAA.

Complaints
If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. 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/.

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

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

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

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

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

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

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

ALABAMA – Medicaid Website: http://myalhipp.com/ Phone: 1-855-692-5447	**ALASKA – Medicaid** The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	**CALIFORNIA – Medicaid** Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+) Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	**FLORIDA – Medicaid** Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid

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

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website:
http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

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

KENTUCKY – Medicaid

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

LOUISIANA – Medicaid

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

MAINE – Medicaid

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

MASSACHUSETTS – Medicaid and CHIP

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

MINNESOTA – Medicaid

Website:
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid

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

MONTANA – Medicaid

Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

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

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-program
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

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

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. In these cases, you should not be charged more than your plan's copayments, coinsurance and/or deductible.

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

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

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

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services

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

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

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

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

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

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:

  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").

  - Cover emergency services by out-of-network providers.

  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, the following information and resources are available to help you understand your rights:

Assistance by telephone – You may contact the U.S. Department of Health & Human Services at (800) 985-3059 to discuss whether you may have any surprise billing protection rights for your situation.

Available online assistance – You can also visit the U.S. Centers for Medicare & Medicaid Services website to learn more about protections from surprise medical bills.