2027

Employee Benefits Program

January 1, 2027 - December 31, 2027

Questions, Problems or Concerns

Our goal is to make certain that you receive the correct coverage under the benefits plan. We are here to help with any issues that may arise. If you require assistance, have your ID number or Social Security Number available and follow these steps:

- **For claims assistance** call the applicable insurance carrier. Have your ID number, date of service, and provider name available.
- If you require further assistance, contact Gallagher. HACAP has partnered with Gallagher as our benefits administrator for expert assistance with benefit related questions, plan procedures, life events and claim issues.
- **Do you need an ID card?** If you do not have an ID card, please contact the insurance carrier to order your ID card or go online to the carrier's site to download an ID card.

Important Contact Information

Carrier	Group #	Web / Email	Phone
Medical and Prescription Wellmark	57028	www.wellmark.com	1-800-524-9242
Health Savings Account HealthEquity	38080	https://my.healthequity.com/ClientLogin.aspx	1-866-346-5800
Flexible Spending Accounts iSolved	KA569	www.isolvedbenefitservices.com/wdm	1-515-224-9400
Dental Delta Dental	32713	www.deltadentalia.com	1-800-544-0718
Vision Vision Service Plan	30094655	www.vsp.com	1-800-877-7195
Basic Life and AD&D Insurance **Supplemental Life Insurance** The Hartford	922101	www.thehartford.com	1-877-320-0484
Short-Term Disability **Vol. Long-Term Disability** **Vol. Critical Illness and Accident Insurance** The Hartford	922101	www.thehartford.com	1-877-320-0484
403(b) Retirement Plan		www.principal.com/welcome	1-800-547-7754
Employee Assistance Program (EAP) Employee Family Resources (EFR)		www.efr.org	1-800-327-4692



Welcome to your Employee Benefits!

HACAP is pleased to offer a wide range of benefits to its employees and their families. These company-sponsored benefits are an important part of a total compensation package. They represent both a valuable asset to our employees and to their families and demonstrate an investment by HACAP in our employees. We are proud of our compensation benefits program and are committed to continuously improving the plans that make up our benefits offerings.

This guide was created to answer some of the questions you may have about your benefits. Please read it carefully along with any supplemental materials you receive.

If you have any benefits related questions or concerns, please do not hesitate to call the Employee Benefits Helpline.

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PLEASE NOTE: This booklet provides a summary of the benefits available but is not your Summary Plan Description (SPD). HACAP reserves the right to modify, amend, suspend, or terminate any plan at any time, and for any reason without prior notification. The plans described in this book are governed by insurance contracts and plan documents, which are available for examination upon request. We have attempted to make the explanations of the plans in this booklet as accurate as possible. However, should there be a discrepancy between this booklet and the provisions of the insurance contracts or plan documents, the provisions of the insurance contracts or plan documents will govern. In addition, you should not rely on any oral descriptions of these plans, since the written descriptions in the insurance contracts or plan documents will always govern.

How to Enroll

Open Enrollment Period

HACAP's annual enrollment period will be held **November 9 –November 20, 2026.**
Log on to the enrollment site to review your current benefits, make any plan changes, or update dependent and/or beneficiary information.

Newly Hired/Eligible Employees

New hires and newly eligible employees **MUST** complete online enrollment even if choosing to waive coverage to provide beneficiary information for your company-paid life insurance. Coverage, if elected, will begin on your date of hire, provided you enroll online within **30 days of your date of hire.**

Have social security numbers and birth dates for all dependents and beneficiaries available prior to logging on.

Enrolling In Your Benefits

Please review this guide to gain a full understanding of the plans being offered. Be sure to go online between **November 9 – November 20,** or within 30 days of becoming eligible, to review your current benefits and make any changes for the upcoming plan year.

Log into UKG to begin the enrollment process



The enrollment process will be broken down into 4 steps:

- **Your Information**
  Employee - Verify accuracy of all information and add an email address.
  Family - You may add new or edit existing dependent information as necessary. Please remember to include date of birth, gender and social security numbers for all dependents.
- **Your Benefits** - You will be automatically enrolled in benefits that are company-paid. These benefits will be checked off as completed. The first incomplete benefit will open up and guide you through the enrollment process.
- **Enroll** - You will be asked to assign beneficiaries, confirm other coverage, do a final review of your elections and confirm.
- **Complete** - After you have made your benefit elections and verified them for accuracy, click **"CLICK SUBMIT."** You will then have the option to e-mail and/or print a copy of the Confirmation Statement for your records.

You can make changes to your selections prior to the enrollment deadline by logging back into the system and clicking on "Change My Elections."

Eligibility

Full-time employees with a schedule of **30 hours per week** are eligible for the benefits described in this guide, unless otherwise stated.

When Benefits Become Effective

Benefits for most benefit plans are effective the first day of the month following your date of hire. Short-Term Disability benefits are effective 12-months after date of hire.

Eligible Dependents

Your dependents are eligible to participate in HACAP's benefit plans. Your eligible dependents include*:

- A spouse to whom you are legally married.
- A dependent child under age 26. Coverage will terminate at the end of the month of the dependent's 26th birthday. Coverage may be extended past the age of 26 for disabled dependents. Dependent children can include natural, adopted children, and stepchildren.

Coverage for eligible dependents generally begins on the same day your coverage is effective. Completed enrollment serves as a request for coverage and authorizes any payroll deductions necessary to pay for that coverage.

**Additional carrier conditions may apply and may vary by state.*



For all benefits except the IPERS and 403(b), you must enroll within 30 days from your date of hire by logging into UKG





Newly Hired/Eligible Employees

New hires and newly eligible employees **MUST** complete enrollment even if choosing to waive coverage to provide beneficiary information for your company-paid life insurance.

Pre-Tax Benefits: Section 125

HACAP's benefit plans utilize Section 125. This enables you to elect to pay premiums for health, dental, vision and flexible spending account coverage on a pre-tax basis. When you use pre-tax dollars, you will reduce your taxable income and have fewer taxes taken out of your paycheck. Under Section 125, you can have more spendable income than if the same deductions were taken on an after-tax basis.

Pre-tax Note: When you pay for your dependent's benefits on a pre-tax basis you are certifying that the dependent meets the IRS' definition of a dependent. [IRC §§ 152, 21 (b)(1) and 105(b)]. Children/spouses that do not satisfy the IRS' definition will result in a tax liability to you, such as changing that dependent's election to a post-tax election or receiving imputed income on your W-2 for the dependent's coverage that should not have been taken on a pre-tax basis.







You must submit a qualifying event in UKG 30 days from the life event status change in order to make a change in your benefit selections.

Benefit Changes

The benefit elections you make during open enrollment or as a new hire will remain in effect for the entire plan year. You will not be able to change or revoke your elections once they have been made unless a life event status change occurs.

For purposes of health, dental, vision and flexible spending accounts, you will be deemed to have a life event status change if:

- your marital status changes through marriage, the death of your spouse, divorce, legal separation, or annulment;
- your number of dependents changes through birth, adoption, placement for adoption, or death of a dependent;
- you, your spouse or dependents terminate or begin employment;
- your dependent is no longer eligible due to attainment of age;
- you, your spouse or dependents experience an increase or reduction in hours of employment (including a switch between part-time and full-time employment; strike or lock-out; commencement of or return from an unpaid leave of absence);
- gain or loss of eligibility under a plan offered by your employer or your spouse's employer;
- a change in residence for you, your spouse or your dependent resulting in a gain or loss of eligibility.

In order to be permitted to make a change of election relating to your health, dental or vision coverage due to a life event status change, the change must result in you, your spouse or dependent gaining or losing eligibility for health, dental or vision coverage under this Plan or a plan sponsored by another employer by whom you, your spouse or dependent are employed. The election change must correspond with that gain or loss of eligibility.

You may also be permitted to change your elections for health coverage under the following circumstances:

- a court order requires that your child receive accident or health coverage under this plan or a former spouse's plan;
- you, your spouse or dependent become entitled to Medicare or Medicaid;
- you have a Special Enrollment Right;
- there is a significant change in the cost or coverage for you or your spouse attributable to your spouse's employment.

For purposes of all other benefits under the plan, you will be deemed to have a life event status change if the change is on account of and consistent with a change in status, as determined by the plan administrator, in its discretion, under applicable law and the plan provisions.

Benefit Changes continued...

Event	Action Required	Results If Action Not Taken
New Hire:	Make elections within 30 days of hire date. Documentation is required.	You and your dependents are not eligible until the next annual Open Enrollment.
Marriage:	Your new spouse must be added to your elections within 30 days of the marriage date. A copy of the marriage certificate must be presented.	Your spouse is not eligible until the next annual Open Enrollment period.
Divorce:	The former spouse must be removed within 30 days of the divorce. Proof of the divorce will be required. A copy of the divorce decree must be presented.	Benefits are not available for the divorced spouse and will be recouped if paid erroneously.
Birth or adoption of a child:	The new dependent must be enrolled in your elections within 30 days of the birth and adoption, even if you already have family coverage. A copy of the birth certificate, footprints, or hospital discharge papers must be presented. Once you receive the child's Social Security Number, be sure to contact AssuredPartners to update your child's insurance information record.	The new dependent will not be covered on your health insurance until the next annual Open Enrollment period.
Death of a spouse or dependent:	Remove the dependent from your elections within 30 days from the date of death. Death certificate must be presented.	You could pay a higher premium than required and you may be overpaying for coverage.
Your spouse gains or loses employment that provides health benefits:	Add or drop health benefits from your elections within 30 days of the event date. A letter from the employer or insurance company must be presented.	You need to wait until the next annual Open Enrollment period to make any change.
Loss of coverage with a spouse:	Change your elections within 30 days from the loss of coverage. A letter from the employer must be provided.	You will be unable to enroll in the benefits until the next annual Open Enrollment period.
Changing from full-time to part-time employment (without benefits) or from part-time to full- time (with benefits):	Change your elections within 30 days from the employment status change in order to receive COBRA information or to enroll in benefits as a full-time employee. Documentation from the employer must be provided.	Benefits may not be available to you or your dependents if you wait to enroll in COBRA. Full-time employees will have to wait until the annual Open Enrollment period.

If you Experience a Life Event Status Change

Log onto **UKG** to add or drop dependents from your coverage if you experience a life event status change. Click on "Life Events" and a series of easy-to-follow instructions will lead you through the enrollment process.

You must update your elections within 30 days of your life event status change, or you will not be able to make changes until the next annual open enrollment. If adding or removing dependents, you may be required to submit specific documents to Human Resources. The change may be inactive until proper documentation is received and approved. For assistance processing life event status changes, you can contact Human Resouces at hresources@hacap.org .

Medical Coverage

HACAP is proud to offer you a choice between four different medical plans. Coverage under all plans includes comprehensive medical care and prescription drug coverage. The plans also offer many resources and tools to help you maintain a healthy lifestyle. Below is a brief description of each plan.

Wellmark Blue HMO

The Wellmark Blue HMO Plan is a Health Maintenance Organization, or an HMO for short. With this plan, an entire network of health care providers agrees to offer you its services. You will have to select a primary care provider (PCP) who will coordinate all of your health services and care.

Under The HMO Plan, you have 100% coverage for most types of preventative care and have coverage for a variety of specialist visits, specialist visits do not require a referral from your PCP. Additionally, you will pay copayment fees for every non-preventive medical visit.

Alliance Select PPO

The Alliance Select Plan is a Preferred Provider Organization (PPO). With this plan you have the most flexibility for seeking care. You may see any doctor or go to any hospital nationwide, but costs will be lower for in-network services.

Enrolling in a PPO Plan, both you and your family can see any health care provider in the Network network, including specialists, without a referral. You are not required to choose a primary care physician.



We encourage you to download the My Wellmark App and use it for locating providers, monitoring the status of claims, and for viewing your Member ID Card. The app is free and available for iOS and Android.

Alliance Select HDHP PPO

The Wellmark Alliance Select HSA Plan is a High-Deductible Health Plan, or a HDHP for short. This plan functions like a Preferred Provider Organization (PPO) but features a low monthly premium in exchange for a higher deductible. The benefit of this plan is that you will be eligible to enroll in and contribute to a Health Savings Account (HSA). With an HSA your contributions are pre-tax so any amount you contribute is deducted from your taxable income at the end of the year. The money in your HSA can be spent on eligible health care expenses including copays, prescriptions, dental treatment, and more.

As with a PPO, both you and your family can see any health care provider in the Network network, including specialists, without a referral. You are not required to choose a primary care physician.

How Our Medical Plans Work

Let's get started!

Get Your Preventive Care

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ALL PLANS PAY 100%*

Here are some key things that you get at no charge (*In-Network Providers Only):

- Adult physicals
- Mammograms
- Well-child exams and immunizations
- Prostate and colorectal screenings
- Routine prenatal maternity services
- Pap tests

Age and gender appropriate visit / screenings

Wellmark HMO Plans

$950 Blue HMO

You pay the following copays for in-network services:
Office Visit Designated PCP: $20/ Non-Designated $25
Specialist Visit: $25
Urgent Care: $25

$2,000 Blue HMO

You pay the following copays for in-network services:
Office Visit Designated PCP: $20/ Non-Designated $25
Specialist Visit: $50
Urgent Care: $25

Wellmark $2,000 PPO Plan

Office Visit: $20 Copay
Specialist Visit: $40 Copay
Urgent Care: $40 Copay

HDHP/HSA

Need Additional Care or Prescription Drugs?

Meet Your Deductible

Your DEDUCTIBLE is the amount of money you must pay for covered services each year before the plan will start paying for all or part of the services.

YOU PAY 100%
Until you meet your DEDUCTIBLE

For Most Other Care: Meet Your Deductible

YOU PAY 100% Until you meet your DEDUCTIBLE

Pay Your Share

After you meet your deductible for either plan, you'll pay a COPAY or COINSURANCE for most covered services.

20% $ 80%

YOU PAY 20%
PLAN PAYS 80%

Reach the Out-of-Pocket Max

After you reach the OUT-OF-POCKET MAX, the plan will pay 100% of covered expenses for the remainder of the year.

$

PLAN PAYS 100%

Plan year ends

Medical Plan Comparison

	Wellmark Blue $950 HMO In-Network Only, You Pay:	Wellmark Blue $2,000 HMO In-Network Only, You Pay:
Deductible (Individual / Family)	**$950 / $1,900**	**$2,000 / $4,000**
HSA Eligible?	No	No
Out-Of-Pocket Maximum (Individual / Family)	$1,700 / $3,400	$4,000 / $8,000
Preventive Services Well-Child Care Adult Physical Examination Breast Cancer Screening Pap Test	No charge	No charge
Office Visits	$20 PCP / $25 Non-PCP / $25 Specialist	$20 PCP / $25 Non-PCP / $50 Specialist
Virtual Visits	No charge	No charge
Urgent Care Centers	$25 per visit	$25 per visit
Lab, X-Ray, Diagnostic (non-hospital)	$25 per visit	$50 per visit
Emergency Room - Facility	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance
Emergency Room - Physician	No charge after deductible	No charge after deductible
Chiropractic	$25 per visit	$25 per visit

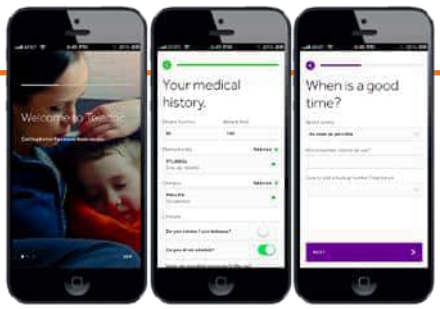
This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.

	Alliance Select PPO $2,000 In-Network Only, You Pay:	Alliance Select PPO $2,000 OUT OF NETWORK, You Pay:
Deductible (Individual / Family)	**$2,000 / $6,000**	**$6,000 / $18,000**
HSA Eligible?	No	No
Out-Of-Pocket Maximum (Individual / Family)	$6,000 / $12,700	$12,000 / $25,400
Preventive Services Well-Child Care Adult Physical Examination Breast Cancer Screening Pap Test	No charge	Deductible, then 50% coinsurance
Office Visits	$20 PCP / $40 Specialist	Deductible, then 50% coinsurance
Virtual Visits	No charge	NA
Urgent Care Centers	$40 per visit	Deductible, then 50% coinsurance
Lab, X-Ray, Diagnostic (non-hospital)	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance
Emergency Room - Facility	$250	$250
Chiropractic	$20 per visit	Deductible, then 50% coinsurance

Medical Plan Comparison

	Alliance Select PPO $2,500 HDHP In-Network Only, You Pay:	Alliance Select PPO $2,500 HDHP OUT OF NETWORK, You Pay:
Deductible (Individual / Family)	**$2,500 / $5,000**	**$3,500 / $7,000**
HSA Eligible?	Yes	Yes
Out-Of-Pocket Maximum (Individual / Family)	$2,500 / $5,000	$3,500 / $7,000
Preventive Services Well-Child Care Adult Physical Examination Breast Cancer Screening Pap Test	No charge	Deductible
Office Visits	Deductible	Deductible
Virtual Visits	$69 per visit	NA
Urgent Care Centers	Deductible	Deductible
Lab, X-Ray, Diagnostic (non-hospital)	Deductible	Deductible
Emergency Room - Facility	Deductible	Deductible
Chiropractic	Deductible	Deductible

This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.



Doctors on Demand

HACAP has partnered with Doctors on Demand to provide you with 24/7/365 on-demand access to a national network of U.S. board-certified doctors through the convenience of phone, video or mobile app visits. Doctors on Demand can diagnose, treat and prescribe medication, when necessary, for a variety of issues. It's more convenient access to quality healthcare, when and where you need it.

Medical Plan Premiums

Plan Cost Per Pay Period (26)	Wellmark Blue HMO $950	Wellmark Blue HMO $2,000
Employee Only – FULL TIME	$83.74	$75.48
PART TIME	*$92.12*	*$83.02*
Employee + Spouse	$170.13	$153.19
	$187.14	*$168.51*
Employee + Child(ren)	$157.35	$141.70
	$173.09	*$155.87*
Family	$414.88	$373.48
	$456.37	*$410.82*

Plan Cost Per Pay Period (26)	Alliance Select PPO $2,000
Employee Only	$85.85
PART TIME	*$94.44*
Employee + Spouse	$174.43
	$191.88
Employee + Child(ren)	$161.34
	$177.47
Family	$425.41
	$467.95

Plan Cost Per Pay Period (26)	Alliance Select PPO $2,500 HDHP
Employee Only – FULL TIME	$110.96
PART TIME	*$122.05*
Employee + Spouse	$233.62
	$256.99
Employee + Child(ren)	$192.94
	$212.23
Family	$523.69
	$576.06

This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.

Prescription Coverage

Your prescription drug benefit is part of your Medical plan and is based on a three-tier drug system. Copayment and/or coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned as one of the three tiers. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on to www.mywellmark.com.

Medicare Part D

The prescription drug benefit is creditable coverage – except for the HDHP plan. Medicare-eligible participants need not enroll in a separate Medicare D drug plan.

Rx Mail Order Program

Save time and money by filling maintenance drugs through the mail order program. The Mail Order Program benefits members who are on long-term medications for chronic conditions such as diabetes, high cholesterol, high blood pressure, depression or asthma. By utilizing the Mail Order Program, you can receive a 90-day supply of medication for the equivalent of two retail copayments. That's a savings of one copayment for every 90-day supply.

	Wellmark Blue HMO $950	Wellmark Blue HMO $2,000	Alliance Select PPO $2,000	Alliance Select PPO $2,500 HDHP – NOT CREDITABLE
Tier 1: Generic	$10.00	$10.00	$10.00	Deductible
Tier 2: Preferred Brand	$25.00	$30.00	$40.00	Deductible
Tier 3: Non-Preferred Brand	$50.00	$60.00	$60.00	Deductible
*Specialty Drugs	$50.00	$50.00	30% coinsurance up to $250.00	Deductible

**Plan includes coverage for certain specialty drugs through PrudentRx. Your deductible and coinsurance will be waived for drugs listed on the PrudentRx drug list.*

This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.

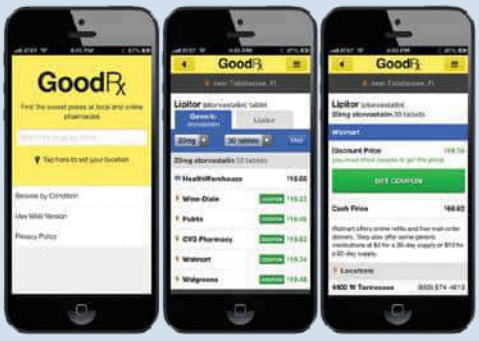
Save money with Generic Drugs

Generic drugs are made with the same active ingredients and produce the same effects in the body as their brand-name equivalents. That's because they're held to the same federal standards for safety and performance as the brand names. Because they're not branded, generics can sell for 30 percent to 80 percent less than their brand-name equivalents.

GoodRx Mobile App

Regardless of which plan you decide to enroll in, we encourage you to download and use the GoodRx Mobile App to help you save on your prescription drug costs. Prices for prescription drugs vary widely between pharmacies. The cost of a prescription may differ by more than $100 between two pharmacies across the street from each other.

GoodRx doesn't sell the medications, they will tell you where you can get the best deal on them. GoodRx will show you prices, coupons, discounts and savings tips for your prescription at pharmacies near you.



Wellmark Health Plan of Iowa

Coverage Period: 01/01/2027 – 12/31/2027
Coverage for: Single & Family | Plan Type: HMO

Hawkeye Area Community Action HMO Plan 1

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

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$950** person/**$1,900** family per calendar year.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care from in-network providers, physician maternity care, in-network prosthetic limbs and services subject to copayments are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No. There are no other deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Health: **$1,700** person/**$3,400** family per calendar year. Drug Card: **$1,700** person/**$3,400** family per calendar year. The In-Network health and drug card out-of-pocket maximum amounts accumulate together.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.wellmark.com or call 1-800-524-9242 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 Designated PCP copay per provider per date of service	Not covered	For this plan you must select a Designated Primary Care Provider (PCP). PCP provider types can be found in the What You Pay section of your plan document.
	Specialist visit	$25 copay per provider per date of service	Not covered	Applies to Non-PCP providers. Hearing exams are covered according to ACA guidelines. $25 copay per provider per date of service for in-network chiropractic services.
	Preventive care/screening/ immunization	No charge	Not covered	One preventive exam and one mammogram per calendar year. Well-child care is covered to age 7. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Independent Lab: $25 copay per provider per date of service Facility: 20% coinsurance	Not covered	For a test in a provider's office or clinic, your cost is included in the cost-share listed above. Waive cost-share on in-network independent lab services for mental health/ chemical dependency.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	For a test in a provider's office or clinic, your cost is included in the cost-share listed above.

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

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is at www.wellmark.com/prescriptions.	Tier 1	$10 copay per prescription	Not covered	Refer to your Blue Rx Value Plus Drug List to determine the tier that applies to a covered drug. 1 copay for 30-day supply. 2 copays for 90-day supply (retail and mail order). Specialty drugs are covered only when obtained through the CVS Specialty Pharmacy Network. Specialty drugs on the PrudentRx drug list (found at Wellmark.com) will have 30% coinsurance. If you enroll with PrudentRx, you will have $0 member cost-share for drugs on the PrudentRx drug list. See wellmark.com/prescriptions for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your plan.
	Tier 2	$25 copay per prescription	Not covered	
	Tier 3	$50 copay per prescription	Not covered	
	Specialty drugs	$50 copay per prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	------None------
	Physician/surgeon fees	20% coinsurance	Not covered	------None------

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

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	For emergency medical conditions treated out-of-network, it is likely you may not be balance billed pursuant to the federal rules developed for implementation of the No Surprises Act.
	Emergency medical transportation	20% coinsurance	20% coinsurance	For covered non-emergent situations, out-of-network ground ambulance services are NOT reimbursed at the in-network level. You may be balance billed for any out-of-network service as established under the rules developed for implementation of the No Surprises Act.
	Urgent care	$25 copay per provider per date of service for facility and physician(s) combined	Not covered	------None------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	------None------
	Physician/surgeon fees	20% coinsurance	Not covered	------None------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $25 copay per provider per date of service Facility: 20% coinsurance	Not covered	------None------
	Inpatient services	20% coinsurance	Not covered	------None------

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

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you are pregnant	Office visits	No charge	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for preventive services. For any in-network services that fall outside of routine obstetric care, the office visit benefits shown above may apply.
	Childbirth/delivery professional services	No charge	Not covered	Benefits shown reflect OB/GYN practitioner services which are typically globally billed at time of delivery for pre-natal, post-natal and delivery services.
	Childbirth/delivery facility services	20% coinsurance	Not covered	------None------
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	------None------
	Rehabilitation services	Office: $25 copay per provider per date of service Facility: 20% coinsurance	Not covered	$25 copay per provider per date of service applies to in-network Physical and Occupational Therapists and Speech Pathologists.
	Habilitation services	Office: $25 copay per provider per date of service Facility: 20% coinsurance	Not covered	$25 copay per provider per date of service applies to in-network Physical and Occupational Therapists and Speech Pathologists.
	Skilled nursing care	20% coinsurance	Not covered	------None------
	Durable medical equipment	20% coinsurance	Not covered	------None------
	Hospice services	20% coinsurance	Not covered	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.
If your child needs dental or eye care	Children's eye exam	$25 copay per provider per date of service	Not covered	One routine vision exam per calendar year. Must be performed by an in-network provider.
	Children's glasses	Not covered	Not covered	------None------
	Children's dental check-up	Not covered	Not covered	------None------

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

Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic surgery
- Custodial care - in home or facility
- Dental care - Adult
- Dental check-up
- Extended home skilled nursing
- Glasses
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Some pharmacy drugs are not covered
- Weight loss programs

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

- Applied Behavior Analysis therapy
- Bariatric surgery
- Chiropractic care
- Infertility treatment (excludes some services)
- Private-duty nursing - short term intermittent home skilled nursing
- Routine eye care - Adult (one vision exam per calendar year)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, you can contact: Wellmark at 1-800-524-9242, Iowa Insurance Division at 515-654-6600, or Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

Wellmark Health Plan of Iowa, Inc. is an independent licensee of the Blue Cross and Blue Shield Association.

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

About These Coverage Examples:

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

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

The plan's overall deductible	$950
PCP copayment	$20
Hospital(facility) coinsurance	20%
Other no charge	No Charge

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$950
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	**$60**
The total Peg would pay is	**$1,810**

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

The plan's overall deductible	$950
Specialist copayment	$25
Hospital(facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$50
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	**$20**
The total Joe would pay is	**$1,170**

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

The plan's overall deductible	$950
Specialist copayment	$25
Hospital(facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$950
Copayments	$100
Coinsurance	$200
What isn't covered	
Limits or exclusions	**$0**
The total Mia would pay is	**$1,250**

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

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

Wellmark Health Plan of Iowa

Coverage Period: 01/01/2027 – 12/31/2027
Coverage for: Single & Family | Plan Type: HMO

Hawkeye Area Community Action HMO Plan 2

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

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,000** person/**$4,000** family per calendar year.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care from in-network providers, physician maternity care, in-network prosthetic limbs and services subject to copayments are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No. There are no other deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Health: **$4,000** person/**$8,000** family per calendar year. Drug Card: **$4,000** person/**$8,000** family per calendar year. The In-Network health and drug card out-of-pocket maximum amounts accumulate together.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.wellmark.com or call 1-800-524-9242 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 Designated PCP copay per provider per date of service $25 Other copay per provider per date of service	Not covered	For this plan you must select a Designated Primary Care Provider (PCP). PCP provider types can be found in the What You Pay section of your plan document.
	Specialist visit	$50 copay per provider per date of service	Not covered	Applies to Non-PCP providers. Hearing exams are covered according to ACA guidelines. $25 copay per provider per date of service for in-network chiropractic services.
	Preventive care/screening/ immunization	No charge	Not covered	One preventive exam and one mammogram per calendar year. Well-child care is covered to age 7. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Independent Lab: $50 copay per provider per date of service Facility: 20% coinsurance	Not covered	For a test in a provider's office or clinic, your cost is included in the cost-share listed above. Waive cost-share on in-network independent lab services for mental health/ chemical dependency.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	For a test in a provider's office or clinic, your cost is included in the cost-share listed above.

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

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is at www.wellmark.com/prescriptions.	Tier 1	$10 copay per prescription	Not covered	Refer to your Blue Rx Value Plus Drug List to determine the tier that applies to a covered drug. 1 copay for 30-day supply. 2 copays for 90-day supply (retail and mail order). Specialty drugs are covered only when obtained through the CVS Specialty Pharmacy Network. Specialty drugs on the PrudentRx drug list (found at Wellmark.com) will have 30% coinsurance. If you enroll with PrudentRx, you will have $0 member cost-share for drugs on the PrudentRx drug list. See wellmark.com/prescriptions for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your plan.
	Tier 2	$30 copay per prescription	Not covered	
	Tier 3	$60 copay per prescription	Not covered	
	Specialty drugs	$50 copay per prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	------None------
	Physician/surgeon fees	20% coinsurance	Not covered	------None------

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

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	For emergency medical conditions treated out-of-network, it is likely you may not be balance billed pursuant to the federal rules developed for implementation of the No Surprises Act.
	Emergency medical transportation	20% coinsurance	20% coinsurance	For covered non-emergent situations, out-of-network ground ambulance services are NOT reimbursed at the in-network level. You may be balance billed for any out-of-network service as established under the rules developed for implementation of the No Surprises Act.
	Urgent care	$25 copay per provider per date of service for facility and physician(s) combined	Not covered	------None------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	------None------
	Physician/surgeon fees	20% coinsurance	Not covered	------None------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $25 copay per provider per date of service Facility: 20% coinsurance	Not covered	------None------
	Inpatient services	20% coinsurance	Not covered	------None------

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

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you are pregnant	Office visits	No charge	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for preventive services. For any in-network services that fall outside of routine obstetric care, the office visit benefits shown above may apply.
	Childbirth/delivery professional services	No charge	Not covered	Benefits shown reflect OB/GYN practitioner services which are typically globally billed at time of delivery for pre-natal, post-natal and delivery services.
	Childbirth/delivery facility services	20% coinsurance	Not covered	------None------
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	------None------
	Rehabilitation services	Office: $25 PCP/$50 Non-PCP copay per provider per date of service Facility: 20% coinsurance	Not covered	$25 copay per provider per date of service applies to in-network Physical and Occupational Therapists and Speech Pathologists.
	Habilitation services	Office: $25 PCP/$50 Non-PCP copay per provider per date of service Facility: 20% coinsurance	Not covered	$25 copay per provider per date of service applies to in-network Physical and Occupational Therapists and Speech Pathologists.
	Skilled nursing care	20% coinsurance	Not covered	------None------
	Durable medical equipment	20% coinsurance	Not covered	------None------
	Hospice services	20% coinsurance	Not covered	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.

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Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If your child needs dental or eye care	Children's eye exam	$50 copay per provider per date of service	Not covered	One routine vision exam per calendar year. Must be performed by an in-network provider.
	Children's glasses	Not covered	Not covered	------None------
	Children's dental check-up	Not covered	Not covered	------None------

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

Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic surgery
- Custodial care - in home or facility
- Dental care - Adult
- Dental check-up
- Extended home skilled nursing
- Glasses
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Some pharmacy drugs are not covered
- Weight loss programs

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

- Applied Behavior Analysis therapy
- Bariatric surgery
- Chiropractic care
- Infertility treatment (excludes some services)
- Private-duty nursing - short term intermittent home skilled nursing
- Routine eye care - Adult (one vision exam per calendar year)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, you can contact: Wellmark at 1-800-524-9242, Iowa Insurance Division at 515-654-6600, or Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

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

About These Coverage Examples:



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

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

The plan's overall deductible	$2,000
PCP copayment	$20
Hospital(facility) coinsurance	20%
Other no charge	No Charge

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$10
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	**$60**
The total Peg would pay is	**$3,370**

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

The plan's overall deductible	$2,000
Specialist copayment	$50
Hospital(facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$50
Copayments	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	**$20**
The total Joe would pay is	**$1,370**

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

The plan's overall deductible	$2,000
Specialist copayment	$50
Hospital(facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	**$0**
The total Mia would pay is	**$2,200**

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

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

Wellmark

Coverage Period: 01/01/2027 – 12/31/2027
Coverage for: Single & Family | Plan Type: PPO

Hawkeye Area Community Action PPO Plan 4

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

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: **$2,000** person/**$6,000** family per calendar year. Out-of-Network: **$6,000** person/**$18,000** family per calendar year.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care, in-network independent labs, in-network prosthetic limbs and services subject to health or drug card copayments are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No. There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Health In-Network: **$6,000** person/ **$12,700** family per calendar year. Health Out-Of-Network: **$12,000** person/**$25,400** family per calendar year. Drug Card: **$6,000** person/ **$12,700** family per calendar year. The In-Network health and drug card out-of-pocket maximum amounts accumulate together.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why this Matters:
Will you pay less if you use a network provider?	Yes. See www.wellmark.com or call 1-800-524-9242 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.



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

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay per provider per date of service	50% coinsurance	Primary Care Provider (PCP) types can be found in the What You Pay section of your plan document.
	Specialist visit	$40 copay per provider per date of service	50% coinsurance	Applies to Non-PCP providers. Hearing exams are covered according to ACA guidelines. $20 copay per provider per date of service for in-network chiropractic services.
	Preventive care/screening/ immunization	No charge	50% coinsurance	One preventive exam and one mammogram per calendar year. Well-child care is covered to age 7. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	For a test in a provider's office or clinic, your cost is included in the cost-share listed above.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	For a test in a provider's office or clinic, your cost is included in the cost-share listed above.

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

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is at www.wellmark.com/prescriptions.	Tier 1	$10 copay per prescription	Not covered	Refer to your Blue Rx Value Plus Drug List to determine the tier that applies to a covered drug. 1 copay or coinsurance for 30-day supply. 3 copays for 90-day supply (retail and mail order). Specialty drugs are covered only when obtained through the CVS Specialty Pharmacy Network. Specialty drugs on the PrudentRx drug list (found at Wellmark.com) will have 30% coinsurance. If you enroll with PrudentRx, you will have $0 member cost-share for drugs on the PrudentRx drug list. See wellmark.com/prescriptions for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your plan.
	Tier 2	$40 copay per prescription	Not covered	
	Tier 3	$60 copay per prescription	Not covered	
	Specialty drugs	30% coinsurance up to $250	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	------None------
	Physician/surgeon fees	20% coinsurance	50% coinsurance	------None------

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Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	$250 copay per facility per date of service for facility and physician(s) combined	$250 copay per facility per date of service for facility and physician(s) combined	For emergency medical conditions treated out-of-network, it is likely you may not be balance billed pursuant to the federal rules developed for implementation of the No Surprises Act.
	Emergency medical transportation	20% coinsurance	20% coinsurance	For covered non-emergent situations, out-of-network ground ambulance services are NOT reimbursed at the in-network level. You may be balance billed for any out-of-network service as established under the rules developed for implementation of the No Surprises Act.
	Urgent care	$40 copay per provider per date of service for facility and physician(s) combined	50% coinsurance	$20 copay per provider per date of service on in-network services for mental health/substance abuse.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	------None------
	Physician/surgeon fees	20% coinsurance	50% coinsurance	------None------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $20 copay per provider per date of service Facility: 20% coinsurance	50% coinsurance	------None------
	Inpatient services	20% coinsurance	50% coinsurance	------None------

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

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for preventive services. For any in-network services that fall outside of routine obstetric care, the office visit benefits shown above may apply.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	Benefits shown reflect OB/GYN practitioner services which are typically globally billed at time of delivery for pre-natal, post-natal and delivery services.
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	------None------
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	------None------
	Rehabilitation services	Office: $20 PCP/$40 Non-PCP copay per provider Facility: 20% coinsurance	50% coinsurance	$20 copay per provider per date of service applies to in-network Physical and Occupational Therapists and Speech Pathologists. Massage therapy is covered 12 visits pre calendar year.
	Habilitation services	Office: $20 PCP/$40 Non-PCP copay per provider Facility: 20% coinsurance	50% coinsurance	$20 copay per provider per date of service applies to in-network Physical and Occupational Therapists and Speech Pathologists. Massage therapy is covered 12 visits pre calendar year.
	Skilled nursing care	20% coinsurance	50% coinsurance	------None------
	Durable medical equipment	20% coinsurance	50% coinsurance	------None------
	Hospice services	20% coinsurance	50% coinsurance	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.
If your child needs dental or eye care	Children's eye exam	20% coinsurance	50% coinsurance	One routine vision exam per calendar year.
	Children's glasses	Not covered	Not covered	------None------
	Children's dental check-up	Not covered	Not covered	------None------

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

Excluded Services & Other Covered Services:

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

- Bariatric surgery
- Cosmetic surgery
- Custodial care - in home or facility
- Dental care - Adult
- Dental check-up
- Extended home skilled nursing
- Glasses
- Hearing aids
- Infertility treatment
- Long-term care
- Routine foot care
- Some pharmacy drugs are not covered
- Weight loss programs

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

- Acupuncture (12 visits per calendar year)
- Applied Behavior Analysis therapy
- Chiropractic care
- Most coverage provided outside the U.S.
- Private-duty nursing - short term intermittent home skilled nursing
- Routine eye care - Adult (one exam per calendar year)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, you can contact: Wellmark at 1-800-524-9242, Iowa Insurance Division at 515-654-6600, or Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

Wellmark Blue Cross and Blue Shield of Iowa is an independent licensee of the Blue Cross and Blue Shield Association.

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

About These Coverage Examples:

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

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

The plan's overall deductible	$2,000
PCP copayment	$20
Hospital(facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$100
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	**$60**
The total Peg would pay is	**$3,960**

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

The plan's overall deductible	$2,000
Specialist copayment	$40
Hospital(facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$50
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	**$20**
The total Joe would pay is	**$1,470**

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

The plan's overall deductible	$2,000
Specialist copayment	$40
Hospital(facility) copayment	$250
Other coinsurance	20%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	**$0**
The total Mia would pay is	**$2,200**

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

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

Wellmark

Hawkeye Area Community Action HDHP PPO PLAN 3

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

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: **$2,500** person/**$5,000** family per calendar year. Out-of-Network: **$3,500** person/**$7,000** family per calendar year.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-network preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No. There are no other deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: **$2,500** person/**$5,000** family per calendar year. Out-Of-Network: **$3,500** person/**$7,000** family per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.wellmark.com or call 1-800-524-9242 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	0% coinsurance	------None------
	Specialist visit	0% coinsurance	0% coinsurance	Hearing exams are covered according to ACA guidelines.
	Preventive care/screening/ immunization	No charge	0% coinsurance	One preventive exam and one mammogram per calendar year. Well-child care is covered to age 7. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	0% coinsurance	------None------
	Imaging (CT/PET scans, MRIs)	0% coinsurance	0% coinsurance	------None------

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

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is at www.wellmark.com/prescriptions.	Tier 1	0% coinsurance	Not covered	Refer to your Blue Rx Value Plus Drug List to determine the tier that applies to a covered drug. You pay the discounted cost of your prescription drugs until your in-network deductible is met. 30-day supply for prescription drugs. 90 day prescription maximum. Specialty drugs are covered only when obtained through the CVS Specialty Pharmacy Network. Specialty drugs on the PrudentRx drug list (found at Wellmark.com) will have 30% coinsurance. If you enroll with PrudentRx, you will have $0 member cost-share for drugs on the PrudentRx drug list once your deductible is met. See wellmark.com/prescriptions for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your plan.
	Tier 2	0% coinsurance	Not covered	
	Tier 3	0% coinsurance	Not covered	
	Specialty drugs	0% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	0% coinsurance	------None------
	Physician/surgeon fees	0% coinsurance	0% coinsurance	------None------
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	For emergency medical conditions treated out-of-network, it is likely you may not be balance billed pursuant to the federal rules developed for implementation of the No Surprises Act.
	Emergency medical transportation	0% coinsurance	0% coinsurance	For covered non-emergent situations, out-of-network ground ambulance services are NOT reimbursed at the in-network level. You may be balance billed for any out-of-network service as established under the rules developed for implementation of the No Surprises Act.
	Urgent care	0% coinsurance	0% coinsurance	------None------

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Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	0% coinsurance	------None------
	Physician/surgeon fees	0% coinsurance	0% coinsurance	------None------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	0% coinsurance	------None------
	Inpatient services	0% coinsurance	0% coinsurance	------None------
If you are pregnant	Office visits	0% coinsurance	0% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	0% coinsurance	0% coinsurance	Benefits shown reflect OB/GYN practitioner services which are typically globally billed at time of delivery for pre-natal, post-natal and delivery services.
	Childbirth/delivery facility services	0% coinsurance	0% coinsurance	------None------
If you need help recovering or have other special health needs	Home health care	0% coinsurance	0% coinsurance	------None------
	Rehabilitation services	0% coinsurance	0% coinsurance	------None------
	Habilitation services	0% coinsurance	0% coinsurance	------None------
	Skilled nursing care	0% coinsurance	0% coinsurance	------None------
	Durable medical equipment	0% coinsurance	0% coinsurance	------None------
	Hospice services	0% coinsurance	0% coinsurance	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.
If your child needs dental or eye care	Children's eye exam	0% coinsurance	0% coinsurance	One routine vision exam per calendar year.
	Children's glasses	Not covered	Not covered	------None------
	Children's dental check-up	Not covered	Not covered	------None------

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Excluded Services & Other Covered Services:

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

- Acupuncture
- Cosmetic surgery
- Custodial care - in home or facility
- Dental care - Adult
- Dental check-up
- Extended home skilled nursing
- Glasses
- Hearing aids
- Long-term care
- Routine foot care
- Some pharmacy drugs are not covered
- Weight loss programs

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

- Applied Behavior Analysis therapy
- Bariatric surgery
- Chiropractic care
- Infertility treatment (excludes some services)
- Most coverage provided outside the U.S.
- Private-duty nursing - short term intermittent home skilled nursing
- Routine eye care - Adult (one exam per calendar year)

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Does this plan provide Minimum Essential Coverage? Yes

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Does this plan meet the Minimum Value Standards? Yes

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

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About These Coverage Examples:

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

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

The plan's overall deductible	$2,500
PCP coinsurance	0%
Hospital(facility) coinsurance	0%
Other coinsurance	0%

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

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

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

The plan's overall deductible	$2,500
Specialist coinsurance	0%
Hospital(facility) coinsurance	0%
Other coinsurance	0%

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	**$20**
The total Joe would pay is	**$2,520**

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

The plan's overall deductible	$2,500
Specialist coinsurance	0%
Hospital(facility) coinsurance	0%
Other coinsurance	0%

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

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

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

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

Wellmark Language Assistance

Discrimination is against the law

Wellmark complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes. Wellmark does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Wellmark

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call 800-524-9242.

If you believe that Wellmark has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Wellmark Civil Rights Coordinator, 1331 Grand Avenue, Station 3E417, Des Moines, IA 50309-2901, 515-376-6500, TTY 888-781-4262, Fax 515-376-9055, Email **CRC@Wellmark.com**. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Wellmark Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

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

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

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

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

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

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية، المجانية. اتصل بالرقم ٢٤٢٩-٤٢٥-٠٠٨ أو (خدمة الهاتف النصي: ٨٨٨-١٨٧-٢٦٢٤).

ສ່ວນ, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານ ໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ຫາ. (TTY: 888-781-4262.)

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

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

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

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

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

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

တtill:ဒုးသုဉ်ညါ–နမ့ါကတိၤကညီကျိာ်,ကျိာ်တtill်မၤစၢၤတtill်ဖံးတtill်မၤတဖဉ်,လၢတဘဉ်လာ်ဘူးလဲ,အိဉ်လၢနှဂီၢ်လီၤ.ဆဲးကျိးဆူ ၈၀၀–၅၂၄–၉၂၄၂မ့တမ့ါ(TTY:၈၈၈–၇၈၁–၄၂၆၂)တကွာ်.

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

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

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

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

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

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

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

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Health Savings Accounts

Only Alliance Select PPO $2,500 HDHP Participants are Eligible

If you enroll in the **Alliance Select PPO $2,500 HDHP Plan**, a Health Savings Account (HSA) employee contributions are deposited at HealthEquity per pay period for expenses, as defined by the Internal Revenue Service.

The account acts like a regular savings account and accrues interest. The money in the account is owned by you and is fully portable. Funds can accumulate over time and roll over each year. If you use the funds for qualified health care expenses, you will pay no taxes. If you use the money for other expenses, you will pay a tax and a penalty fee.

HACAP will contribute to a participant's HSA Account

Employee: $900 per plan year
Employee + Children: $2,500 per plan year
Employee + Spouse: $2,500 per plan year
Family: $2,500 per plan year

How you save with an HSA

As an HSA user, you will save in several ways:

- HSA contributions are not taxed
- You earn tax-free interest on HSA balances
- HSA funds used for qualified medical expenses are not taxed

HSA funds remain yours to grow

With an HSA, you own the account and all contributions. Unlike flexible spending accounts (FSAs), the entire HSA balance rolls over each year and remains yours even if you change health plans, retire or leave HACAP.

Supplement your retirement

Once your HSA balance reaches a set amount that is assigned by your administrator, you may invest your funds for increased earning potential that is also tax-free. After age 65, you can use your HSA much like a 401(k) and withdraw funds for any purpose. Qualified medical expenditures remain tax-free even into retirement.

You can win with an HSA

Regardless of your personal medical situation, an HSA can empower you to maximize savings while building a reserve for the future.

Using your HSA for qualified medical expenses

HSA funds can be used for a variety of qualified medical, dental and vision expenses; for yourself, your spouse, and your qualified dependents. Eligible expenses include:

- Birth control
- Chiropractor
- Contact lenses
- Dental treatment
- Prescription eyeglasses
- Hearing aids
- Physical exams
- Prescriptions
- Stop-smoking programs
- Surgery (non-cosmetic)
- Therapy
- and more...

2027 HSA Annual Contribution Limit:

$4,500 for individual coverage

$9,000 for all other coverage tiers

You can choose to contribute to your HSA on a before-tax basis, up to the IRS annual maximums. If you are or will be age 55 or over during the calendar year, you may also make a "catch-up" HSA contribution of an additional $1,000 each year. Contact HealthEquity to schedule and adjust your contribution amount.

Note: As a taxpayer, it is your responsibility to ensure that your HSA contributions do not exceed the maximum possible for your specific tax situation. Please consult your attorney, CPA or tax adviser about your specific tax situation before deferring monies to your Health Savings Account. The benefits of an HSA, who is qualified to have an HSA, etc. can be found in IRS Publication 969, beginning on page 2. https://www.irs.gov/pub/irs-pdf/p969.pdf

It's *your* money. Why not keep more of it? With an HSA you can.

Now, more than ever, healthcare dollars need to go further. With a Health Savings Account (HSA), you'll pay less in taxes and increase your take-home pay. So enroll in an HSA and keep more of the money you've earned. *That's real savings, real simple.*

What is a Health Savings Account (HSA)?

An HSA works with a high deductible heath plan (HDHP), and allows you to use before-tax dollars to reimburse yourself for eligible out-of-pocket medical expenses for you, your spouse and your dependents, which in turn saves you on taxes and increases your spendable income.

How it Works

You and your employer can deposit money into your HSA account, up to an annual per-person or family limit set by the IRS. When you enroll, an account will be created for you at a sponsor bank. You'll be given access to a secure, easy-to-use web portal where you can track your account balance, view your investment accounts and submit requests for reimbursements.

In addition, you'll receive a convenient prepaid benefits card to make it easy to access the money in your HSA. The card contains the value of your HSA account and you can use it to pay for eligible services and products not covered by your health insurance. When you use the card, payments are automatically withdrawn from your account, so there are no out- of-pocket costs and you won't have to submit receipts to verify the purchase. Just swipe the card and go. It's that easy!

Benefits to You:

- An HSA is yours. Funds in your HSA account stay with you, even if you change jobs.
- Contribute tax free. An HSA reduces your taxable income. The money is tax free both when you put it in and when you take it out to cover qualified medical expenses.
- Grow funds tax free. An HSA grows with you. If you maintain a minimum balance of $1,000 your additional funds may be invested in mutual funds yielding tax-free earnings.
- Spend tax free. Withdrawals used for eligible expenses are tax free.

Plan for the future. Until you turn 65, withdrawals you use for non-eligible expenses will be taxed at your regular income tax rate but won't incur additional penalties. After you turn 65, or if you become disabled, your HSA account becomes similar to a regular IRA.

+HSA

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You can use your HSA dollars and your prepaid benefits card to pay for:

- Routine health care: office visits, X-rays, lab work
- Hospital expenses: room and board, surgery
- Medications: prescription and over-the- counter (OTC) drugs when prescribed by a physician
- Dental care: cleanings, fillings, crowns
- Vision care: eye exams, glasses, contacts
- Copays and coinsurance (the portions of health care bills paid by you)
- Eligible over-the-counter (OTC) items* such as:
  - First Aid Dressings and Supplies – bandages, rubbing alcohol
  - Contact Lens Solutions/Supplies
  - Diagnostic Products like thermometers, blood pressure monitors, cholesterol testing
  - Insulin and Diabetic Testing Supplies

*The list of eligible OTC items changed per the Patient Protection and Affordable Care Act of 2010. Contact your Plan Administrator for more information or visit www.irs.gov for details.

Learn more during open enrollment!

The amount you save in taxes with a Health Savings Account will vary depending on the amount you set aside in the account, your annual earnings, whether or not you pay Social Security taxes, the number of exemptions and deductions you claim on your tax return, your tax bracket and your state and local tax regulations. Check with your tax advisor for information on you participation will affect your tax savings.

This brochure highlights some of the benefits of a prepaid benefits card. If there is a discrepancy between this material and your official plan document, the plan document will govern. Evolution1 reserves the right to amend or modify the services at any time.

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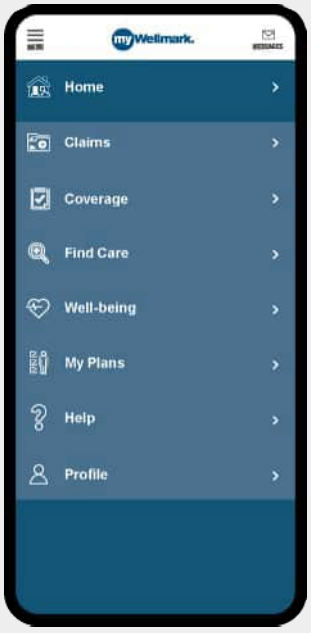
Wellmark



Go MOBILE

Manage your health with the Wellmark® Blue Cross® and Blue Shield® app



For illustrative purposes only

Use these helpful tools on-the-go:

CLAIMS — Track the status of claims, along with sort and filter capabilities. Opt-in for digital Explanation of Benefits (EOB) to get notifications when they're ready.

COVERAGE — The app features your personalized health benefits right at your fingertips, which include copay and deductible amounts and out-of-pocket maximums.

FIND CARE — Find in-network physical and mental health care providers to help save you money. You can also access patient reviews and ratings for hospitals and doctors.

FIND COSTS — Use the cost estimator tool to find how much you'll pay for common procedures and services.

WELL-BEING SERVICES — Take a mental health or wellness assessment. Get discounts with Blue365®. Read the latest health and wellness news and find additional well-being resources.

VIEW AND EMAIL your ID card from your smartphone.



Get the care you need, when you need it.

In addition to finding important information about your health plan benefits, the Wellmark mobile app can help you get the care you need.

- **VIEW PROVIDERS AND HOSPITALS** within the Wellmark health plan network.
- **FIND THE CLOSEST PROVIDER OR FACILITY** using GPS technology.
- **VIEW A MAP OR GET DRIVING DIRECTIONS** to your doctor or hospital.
- **SHARE PROVIDER, DENTIST OR FACILITY INFORMATION** by text or email, or save to your favorites for easy access in the future.
- **CONNECT DIRECTLY** to your health care provider's office or to a health professional.
- **GET HEALTH ANSWERS** over the phone with ease.

Register today!

Download the free Wellmark mobile app at myWellmark.com, the App Store® or on Google Play™.

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Blue365® is a discount program available to members who have medical coverage with Wellmark. This is not insurance.

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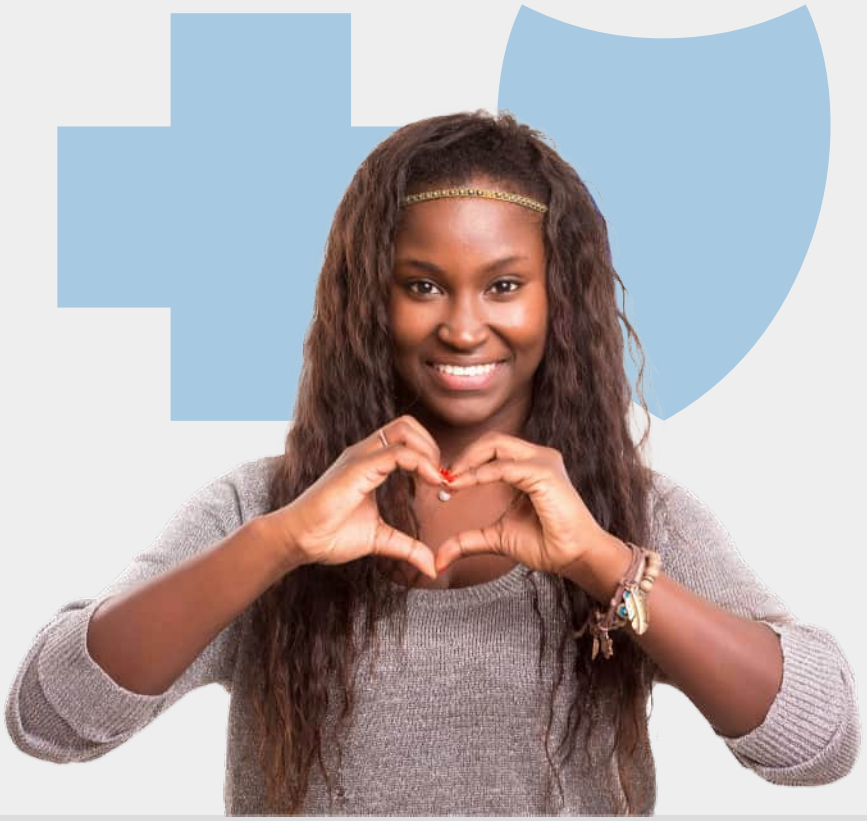
Wellmark

Feeling better **should be easy**



Visit a doctor on your smartphone, tablet or computer from virtually anywhere.

Connect in minutes

Same day mental health appointments are available. You can also choose your provider and see a therapist or psychiatrist within days rather than months. Plus, get treatment for 90 percent of all common ER complaints, from common colds to uncommon rashes, whenever and wherever you're comfortable.

Get treatment for:

- **Mental health**[1]
- **Cold and flu**
- **Bronchitis and sinus infections**
- **Urinary tract infections**
- **Sore throats**
- **Allergies**
- **Fever**
- **Headache**
- **Pink eye**
- **Skin conditions**

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



Getting started is easy.

1. Scan the QR code to visit. **DoctorOnDemand.com/Wellmark** and download the Doctor On Demand® app.
2. Have your Wellmark Blue Cross and Blue Shield member ID card ready.
3. Create an account or sign in to begin your visit.
4. Pick your provider. Select the next available appointment or find the time best for your schedule.

24/7 QUESTIONS: Call 800-997-6196

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

Safe, secure and protected

Your Wellmark health insurance coverage keeps you safe, secure and protected from more than the cost of health care. Just by being a member, you and your dependents have exclusive, free access to identity protection services called IDX™ Identity. It's just another way you get more as a Wellmark member.

Priceless peace of mind

Join thousands of people around the country who have already chosen IDX Identity for identity protection services.

With IDX Identity, you can:

- Monitor your credit record.
- Keep track of your online activity 24 hours a day, seven days a week.
- Have access to complete identity recovery if fraudulent activity is found.



IDX™ The Privacy Platform

Enroll in identity protection services today!

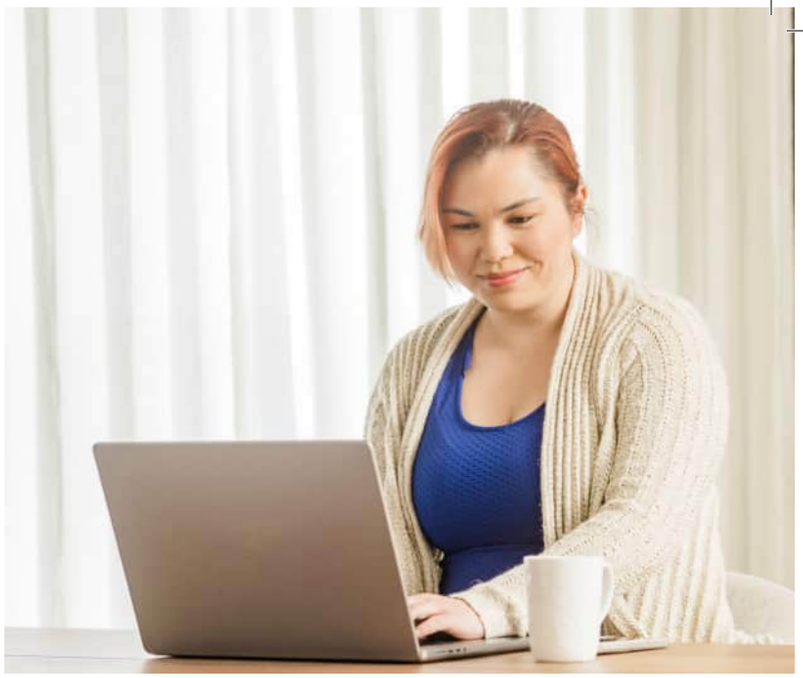
Register or sign in to myWellmark® at myWellmark.com to get started.

1. Select **Identity Protection** from the bottom of the myWellmark homepage. On the mobile app, this is towards the bottom of the navigation menu.
2. Select **Enroll Now** from the IDX home page.
3. Fill out the **Group ID and Subscriber ID** (also known as your Wellmark ID number). Both are found on your Wellmark ID card.
4. Enter your personal information and create a **username** and **password**.
5. To **activate credit monitoring**, enter your birth date and Social Security number.

Rather enroll over the phone?

Just call 866-486-4812

and make sure you have your Wellmark ID card handy.



Identity protection services aren't the only ways you **get more for being a Wellmark member.**

As part of your health plan, you also have access to products and services like:

myWellmark®

Your one-stop-shop for tools, resources and insights to help you manage health care spending and live a healthier life.

Blue365®

Find exclusive ways to save on top wellness services and products you use every day.

BeWell 24/7®

Get connected with a real person who can help you with a variety of health-related concerns. Just call **844-84-BEWELL (239355)**.

Blue℠

Simply visit **Wellmark.com/Blue** to stay informed on health plan updates and the latest in health and wellness.

Wellmark.

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IDX™ Identity is an independent company providing identity protection services on behalf of Wellmark Blue Cross and Blue Shield.

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Dental Coverage

Delta Dental PPO

Delta Dental offers you flexibility to see the provider of your choice each time you seek dental care. You can find a Delta Dental network dentist online at www.deltadental.com, or by calling 1-800-544-0718.

	Delta Dental PPO Network
Calendar Year Maximum	$750
Calendar Year Deductible Per Individual / Per Family	$25 / $75
Preventive & Diagnostic Care Oral Exams, Cleanings, Routine X-Rays, Fluoride Application	100%, No Deductible
Basic Restorative Care Fillings, Simple Extractions, Anesthetics, Routine Oral Surgery, Sealant Applications, Space Maintainers, Posterior Composites w/ Alternate Processing	80%, After Deductible
Major Restorative Care Root Canals, Periodontal Services, Crowns, Inlays, Onlays, Dentures, Bridges, Stainless Steel/Resin Crowns, Repairs and Adjustments to Dentures and Bridges	50%, After Deductible
Orthodontia Coverage for Dependents up to age 19	50%, No Ortho Deductible
Orthodontic Lifetime Maximum	$750

If you elect coverage, HACAP pays 100% of the premium

This dental plan includes the Annual Maximum Carryover – To Go for carryover of unused Benefit Period Maximums for the next benefit contact year.

This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.

HACAP

Group Number: 32713

Benefits Effective: 1/1/2027 to 12/31/2027

SUMMARY OF COVERAGE	Delta Dental Premier® Dentist	Out-of-Network Dentist
Deductible		
Individual	$25*	$25*
Family	$75*	$75*
Annual Benefit Maximum per person per calendar year	$750	
BENEFIT CATEGORIES	**Coinsurance paid by member**	
Diagnostic & Preventive Services routine check-ups, teeth cleaning, bitewing x-rays, full mouth x-rays, fluoride	0%	0%
Routine & Restorative Services cavity repair, tooth extractions, general anesthesia/sedation, routine oral surgery, emergency treatment	20%	20%
Posterior Composites silver filling on back teeth**	20%	20%
Endodontic Services root canals and therapy	50%	50%
Periodontal Services non-surgical procedures, gum and bone diseases, surgical procedures, perio maintenance therapy	50%	50%
High Cost Restorations repair crowns, crowns, recementing crowns	50%	50%
Prosthetics bridges, dentures, repairs and adjustments	50%	50%
Corrective Orthodontia Benefit & Lifetime Maximum Child Only	50% coinsurance and $750 lifetime maximum.	
To Go℠	Annual benefit maximum carry over.	

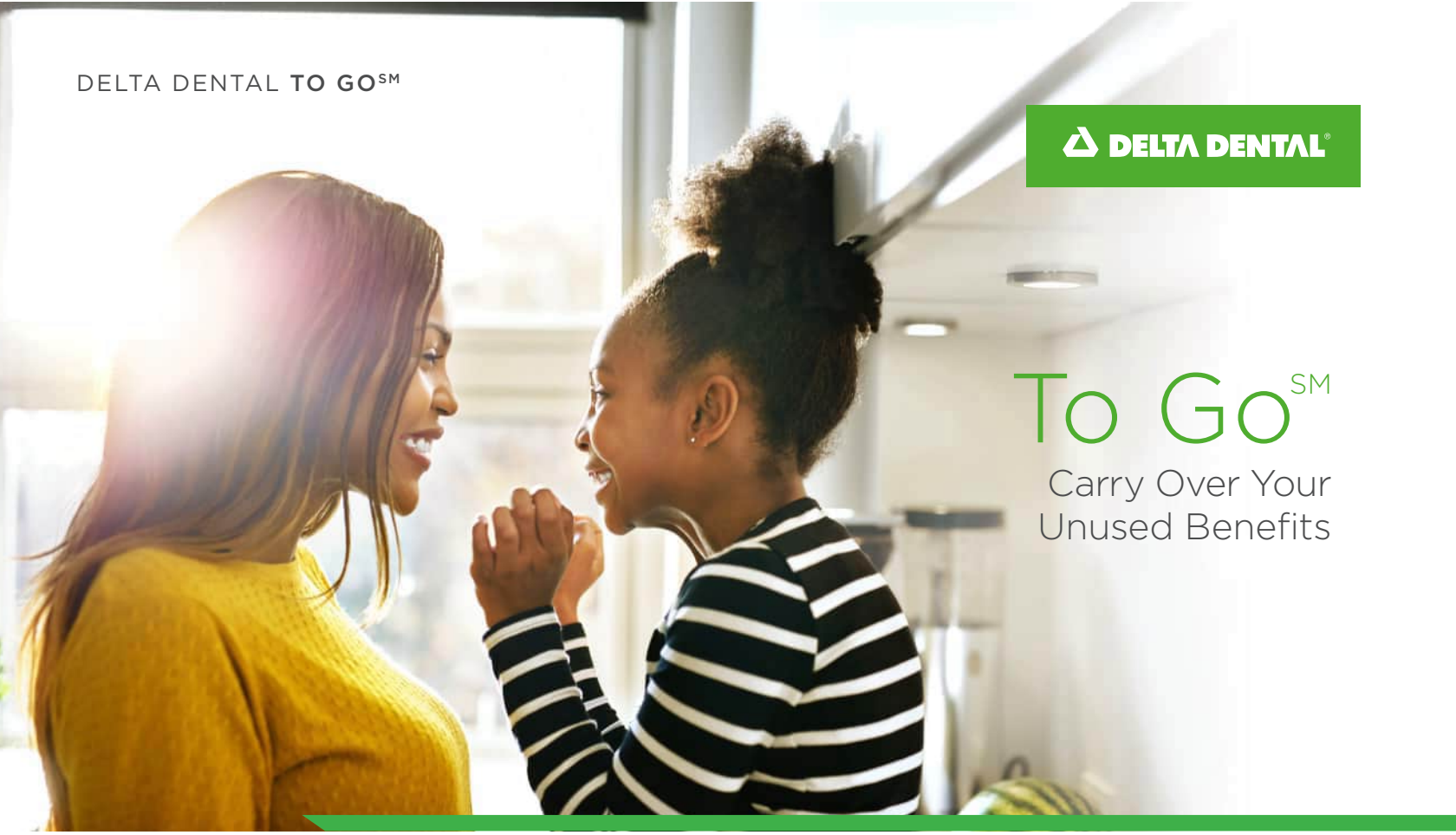
*Deductible is waived for diagnostic and preventive care.

Orthodontia benefits for eligible children to age 19 and full-time students eligible to age 19.

**If you choose a tooth-colored filling for your back (posterior) teeth, benefits are limited to the amount paid for a silver filling. You are responsible for paying the difference.

Percentages shown are what the member pays. Eligible children to age 26. Full-time (unmarried) students eligible to age 26.

The information on this page summarizes your benefits. This is a general description of your benefits. If you do not see a service listed, please see your benefits document for a full description of coverage.



To Go℠

Carry Over Your Unused Benefits

INCREASE YOUR ANNUAL BENEFIT MAXIMUM

To Go℠ allows you to carry over a portion of your unused annual maximums from one benefit period to the next. This benefit offers more flexibility and helps you plan for more extensive and costly dental treatments in subsequent years.

HOW IT WORKS

For example, if your plan has an annual maximum of $1,500, here is how you can use To Go.

YEAR 1		YEAR 2		YEAR 3	
Annual Benefit Maximum	$1,500	Annual Benefit Maximum	$1,500	Annual Benefit Maximum	$1,500
Eligible Benefit Used	$500	To Go Benefit from Year 1	$1,000	To Go Benefit from Year 2	$1,500
Unused Annual Benefit Maximum	$1,000	Year 2 Annual Benefit Maximum	$2,500	Year 3 Annual Benefit Maximum	$3,000
To Go – Annual Maximum Carryover (for use in year 2)	$1,000	Eligible Benefit Used	$500	Eligible Benefit Used	$1,500
		Unused Annual Benefit Maximum	$2,000	Unused Annual Benefit Maximum	$1,500
		To Go – Annual Maximum Carryover (for use in year 3)	$1,500*	To Go – Annual Maximum Carryover (for use in year 4)	$1,500*

QUESTIONS?

If you have any questions about your dental benefits, visit the Delta Dental website at deltadentalia.com and log into the Member Connection or you can call customer service at 800-544-0718.

To Go Guidelines:

1. Your plan must have coverage for major services, and these services may not be subject to any benefit waiting periods. If you make a change that impacts your benefit period, your To Go balance may restart. If you are not covered under the plan for the full benefit period, you will receive a pro-rated amount the first year.
2. You must have submitted at least one claim during the benefit plan year.
3. The carryover amount may not exceed the amount of the regular annual maximum and the total combined annual maximum may not exceed twice the regular annual maximum.

* The To Go – Annual Maximum Carryover amount cannot exceed the annual benefit maximum.

Delta Dental of Iowa | 9000 Northpark Drive | Johnston, IA 50131 | 800-544-0718 | deltadentalia.com

2659-F10250 01/2021

Vision Coverage



Vision Service Plan (VSP)

Choose a VSP doctor or any other provider from the VSP Network: *VSP Signature*. To find a VSP provider, visit www.vsp.com or call 1-800-507-3800. At your appointment, tell them you have VSP. There's no ID card necessary. VSP will handle the rest—there are no claim forms to complete when you see a VSP doctor!

Benefit	Description	Copay	Frequency
WellVision Exam	Focuses on your eyes and overall wellness Routine retinal screening	$10 Up to $39	Every 12 months
Prescription Glasses		$25	
Frame	$130 allowance for a wide selection of frames $150 allowance for featured frame brands 20% savings on the amount over your allowance $130 Walmart/Sam's Club frame allowance $70 Costco® frame allowance	Included in Prescription Glasses	Every 24 months
Lenses	Single vision, lined bifocal, and lined trifocal lenses Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every 12 months
Lens Enhancements	Standard progressive lenses Premium progressive lenses Custom progressive lenses Average 20-25% off other lens options	$0 $95 - $105 $150 - $175	Every 12 months
Contacts (instead of glasses)	$130 allowance for contacts; copay does not apply Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
Extra Savings	**Glasses and Sunglasses:** Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. **Retinal Screening:** No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam. **Laser Vision Correction:** Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.		

Out-of-Network Provider Coverage:

Visit vsp.com for details, if you plan to see a provider other than a VSP network provider.

This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.

Plan Cost Per Pay Period (26)	Vision Service Plan (VSP)
Employee Only	$4.26
Employee + Spouse	$6.82
Employee + Child(ren)	$6.96
Family	$11.22

A Look at Your VSP Vision Coverage

With VSP and Hawkeye Area Community Action Program, your health comes first.



Enroll in VSP® Vision Care to get access to savings and personalized vision care from a VSP network doctor for you and your family.

vsp vision care

Value and savings you love.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras which provide offers from VSP and leading industry brands totaling over $3,000 in savings.

Provider choices you want.

vsp PREMIER edge

With thousands of choices, getting the most out of your benefits is easy at a VSP Premier Edge™ location.

Shop online and connect your benefits.

eyeconic a vsp vision company

Eyeconic® is the preferred VSP online retailer where you can shop in-network with your vision benefits. See your savings in real time when you shop over 70 brands of contacts, eyeglasses, and sunglasses.

Quality vision care you need.

You'll get great care from a VSP network doctor, including a WellVision Exam®. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

Using your benefit is easy!

Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with Exclusive Member Extras. At your appointment, just tell them you have VSP.

More Ways to Save

Extra

$20

to spend on Featured Frame Brands†

bebe · Calvin Klein · COLE HAAN · DRAGON · FLEXON · LONGCHAMP PARIS · and more

See all brands and offers at **vsp.com/offers**.

+

Up to

40%

Savings on lens enhancements‡

Enroll through your employer today.
Contact us: **800.877.7195** or **vsp.com**

Your VSP Vision Benefits Summary

Hawkeye Area Community Action Program and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:
VSP Choice

EFFECTIVE DATE:
1/01/2027

vsp vision care

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Your Coverage with a VSP Provider			
WELLVISION EXAM	• Focuses on your eyes and overall wellness • Routine retinal screening	$10 Up to $39	Every calendar year
ESSENTIAL MEDICAL EYE CARE	• Retinal imaging for members with diabetes covered-in-full • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP network doctor for details.	$20 per exam	Available as needed
PRESCRIPTION GLASSES		**$25**	See frame and lenses
FRAME+	• $150 Featured Frame Brands allowance • $130 frame allowance • 20% savings on the amount over your allowance • $130 Walmart/Sam's Club frame allowance • $70 Costco frame allowance	Included in Prescription Glasses	Every other calendar year
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every calendar year
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements	$0 $95 - $105 $150 - $175	Every calendar year
CONTACTS (INSTEAD OF GLASSES)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every calendar year
ADDITIONAL SAVINGS	**Glasses and Sunglasses** • Discover all current eyewear offers and savings at **vsp.com/offers**. • 20% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from a VSP provider within 12 months of your last WellVision Exam.		
	Laser Vision Correction • Average of 15% off the regular price; discounts available at contracted facilities.		
	Exclusive Member Extras for VSP Members • Contact lens rebates, lens satisfaction guarantees, and more offers at **vsp.com/offers**. • Save up to 60% on digital hearing aids with TruHearing®. Visit **vsp.com/offers**/special-offers/hearing-aids for details. • Enjoy everyday savings on health, wellness, and more with VSP Simple Values.		

YOUR COVERAGE GOES FURTHER IN-NETWORK

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider.

†Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change.
‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.
+Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington. Premier Edge is not available for some members in the state of Texas.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**.

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Flexible Spending Accounts



Eligibility Based on Medical Plan Election

Flexible Spending Accounts (FSA's) offer another way to save money on health care and dependent care expenses. You may submit expenses incurred by any of your dependents, whether they are covered by the insurance plans you have through your employer. Employees need not be enrolled in either medical plan to participate in FSAs.

If you enroll, you fund the accounts via a payroll deduction each pay period. The minimum contribution is $10 per pay. Money that you contribute to your FSAs is not subject to social security taxes, federal, and in most cases, state income taxes.

Account	HSA Participants	Non-HSA Participants	How it works
Healthcare FSA	✗	✓	**Employee-funded.** Can use funds for all healthcare related expenses. Federal regulations do not allow participation in an HSA and this type of account.
Dependent Care FSA	✓	✓	**Employee-funded.** Can use funds for all dependent care related expenses such as day care, nursery school, or elder care.

HCFSA Annual Contribution Limit:
***$3,500**

Health Care Flexible Spending Account (HCFSA)

Federal regulations do not allow participation in an HSA and this type of account. Eligible health care expenses include many of the out-of-pocket expenses you pay to maintain your health and well-being. These include deductibles and coinsurance expenses not covered by your medical plan, expenses for glasses or contact lenses, and more.

DCFSA Annual Contribution Limit:
$7,500
Or $3,750 if you are married and file a separate tax return.

Dependent Care Flexible Spending Account (DCFSA) –

You may use pre-tax dollars from your DCFSA to pay expenses for care when the services enable you and your spouse to work outside of the home. These include expenses for the care of a dependent child, spouse or elderly parent inside your home. Also included are baby-sitters, nursery schools, and day care centers.

Only the portion of expenses that enable you to remain employed are eligible. Educational expenses are not eligible.

The FSA Plan Year is January 1 until December 31.
FSA Open Enrollment is held annually in November.

"Use it or lose it" FSA Rollover Provision - HCFSAs only

HACAP has elected to participate in the FSA rollover provision, allowing employees to rollover up to **$680** from one plan year to the next. You must be enrolled in an HCFSA both plan years. You are still encouraged to consider your expenses carefully before you decide how much to contribute to each Flexible Spending Account. As a reminder, your election will cover the period from January 1 through December 31. You should not contribute more than you are reasonably certain to use.

Flexible Spending Accounts cont.

Eligible Dependents

Regarding your Dependent Care FSA, the IRS defines an eligible dependent as:

- A child under the age of 13 and may be claimed as a deduction for personal exemption under Code Section 151(c).
- A spouse who is physically or mentally incapable of selfcare.
- A disabled person who is physically or mentally incapable of self-care who you provide more than 50% support, and who qualifies as your dependent under Code Section 152.

FSA Claims & Reimbursements

Current Account Users: Requests for reimbursement from your FSA may be made online at **www.isolvedbenefitservices.com** or by completing a claim form. You can also download the iFlex App.

New Account Users – Online setup Please visit **www.isolvedbenefitservices.com** to register for the FSA web site.

1. You will be required to set up a username and password.

FSA Debit Card

An FSA debit card is provided to all HCFSA participants and is available for Dependent Care participants. The debit card is similar to a bank account debit card that allows you to remove funds from your FSA at a merchant payment terminal. By using the debit card to purchase eligible expenses, you avoid paying for a purchase with money out of your pocket. Remember, you still must keep your receipts even when you use the debit card.

Periodically, the IRS requires proof of purchase.

Get started with iFlex Mobile App in minutes.

Changing Your Contribution Amount

Federal regulations prohibit you from changing your enrollment or the amount of your election during the plan year. You are only eligible to change your elections during the year if you have a life event status change. Only benefit changes consistent with the change in status are permitted. Life event status changes that may warrant a change in benefit elections are described on page 3 and 4 of this guide.



iSolved FSA Mobile App

Get your benefits on the go! Save time and hassles with iSolved FSA Mobile App. The app provides the following features:

- Account balances and details
- View Profile Details
- Upload Claims and Submit Receipts
- Recent Transactions and Detail
- View Card PIN
- View all email and SMS alerts
- View Dependents
- View Card Details
- and more…

Download on the App Store

ANDROID APP ON Google Play

isolved Benefit Services



iFlex

Important Information About Prepaid Benefits Cards

General Questions on the Prepaid Benefits Card

1. What is the Prepaid Benefits Card?
   The Prepaid Benefits Card is a special-purpose Mastercard® or Visa® card that gives participants an easy, automatic way to pay for eligible health care/benefit expenses. The card lets participants electronically access the pre-tax amounts set aside in their respective employee benefits accounts such as Flexible Spending Accounts (FSAs), Health Reimbursement Accounts (HRAs), and Health Savings Accounts (HSAs).

2. How does the Prepaid Benefits Card work?
   It works like a Mastercard® or Visa® credit card, with the value of the participant's account(s) contribution stored on it. When participants have eligible expenses at a business that accepts Mastercard® or Visa® debit cards, they simply use their Prepaid Benefits Card. The amount of the eligible purchases will be deducted – automatically – from their account and the pre-tax dollars will be electronically transferred to the provider/merchant for immediate payment.

3. How does the Prepaid Benefits Card change how the participant is reimbursed for expenses?
   Before the Prepaid Benefits Card became available, participants had to pay for their eligible expenses at the time of purchase, submit claim forms along with all receipts, and then wait for the reimbursement to be processed. Checks were issued and mailed to the participants, who then cashed the checks. In essence, participants "paid twice" – through payroll deduction and then at the point of sale – then they had to wait for reimbursement.

   However, with the Prepaid Benefits Card, participants simply swipe their cards and the funds are automatically deducted from their respective benefit account(s) for payment. The card eliminates most out-of-pocket cash outlays and paperwork, as well as the need to wait for reimbursement checks.

4. Is the Prepaid Benefits Card just like other Mastercard® or Visa® cards?
   No. The Prepaid Benefits Card is a special-purpose Mastercard® or Visa® card that can be used only for eligible health care/benefits expenses. It cannot be used, for instance, at gas stations or restaurants. There are no monthly bills and no interest.

Transforming employee experience for a better today and a better tomorrow.

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5. How many Prepaid Benefits Cards will the participant receive?
   The participant will receive two cards (unless the participant has only a Qualified Transportation Account, in which case one card will be issued). If participants would like additional cards for other family members, they should contact their Plan Administrator.

6. Will participants receive a new Prepaid Benefits Card each year?
   No, participants will not receive a new card each year. If the participant will again have a benefit associated with the card for the following plan year – and he/she used the card in the current benefit year – the participant will simply keep using the same card the following year. The card will be loaded with the new annual election amount at the start of each plan year or incrementally with each pay period, based on the type of account(s) the participant has.

7. What if the Prepaid Benefits Card is lost or stolen?
   Participants should call their Plan Administrator to report a card lost or stolen as soon as they realize it is missing, so the Administrator can turn off their current card(s) and issue replacement card(s). There may be a fee for replacement cards.

Getting Started and Activating Your Card

1. How do participants activate the card?
   Participants should call the toll-free number on the activation sticker on the front of the card or visit the web site on the back of the card.

   Participants can use both cards once the first card is activated – they do not need to activate both. They should wait one business day after activation to use their cards. Each card user should sign the card with his or her own name.

2. What dollar amount is on the Prepaid Benefits Card when it is activated?
   For Health Care FSAs, the dollar value on the card will be the annual amount that participants elected to contribute to their respective employee benefit account(s) during their annual benefits enrollment. The available amount may include a carry over based on plan design. It's from that total dollar amount that eligible expenses will be deducted as participants use their cards or submit manual claims.

   Some other types of accounts, like Dependent Care FSAs, HRAs, and transportation accounts, are funded incrementally at each pay period, so it is especially important to be aware of account balances in order to avoid card declines at the point of service.

Using the Card

1. Where may participants use the Prepaid Benefits Card?
   IRS regulations allow participants to use their Prepaid Benefits Cards in participating pharmacies, mail- order pharmacies, discount stores, department stores, and supermarkets that can identify FSA/HRA-eligible items at checkout and accept MasterCard® prepaid cards or Visa® prepaid cards.

   Eligible expenses are deducted from the account balance at the point of sale. Transactions are fully substantiated, and in most cases, no paper follow-up is needed. Participants can find out which merchants are participating by visiting the website on the back of the card or consulting their Plan Administrator.

Some plan designs may also allow participants to use their cards in pharmacies that have certified that 90% of the merchandise they sell is FSA/HRA-eligible. However, since these pharmacies cannot identify the eligible items at the point of sale, another form of auto substantiation or paper follow up will be required.

Participants may also use the card to pay a hospital, doctor, dentist, or vision provider that accepts Mastercard® or Visa®. In this case, EB uses its auto-substantiation technology to electronically verify the transaction's eligibility according to IRS rules. If the transaction cannot be auto substantiated, paper follow-up will be required.

2. Are there places the Prepaid Benefits Card won't be accepted?
Yes. The card will not be accepted at locations that do not offer the eligible goods and services, such as hardware stores, restaurants, bookstores, gas stations and home improvement stores. Cards will not be accepted at pharmacies, mail-order pharmacies, discount stores, department stores, and supermarkets that cannot identify FSA/HRA-eligible items at checkout. The card transaction may be declined. Participants can find out which merchants are participating by visiting the website on the back of the card or consulting their Plan Administrator.

3. If asked, should participants select "Debit" or "Credit"?
Your Prepaid Benefits Card is a prepaid card. But, since there is no "prepaid" selection available, participants should select "Credit." Participants do not need PIN and cannot get cash with the Prepaid Benefits Card.

4. How does the card work in participating pharmacies, discount stores, department stores, and supermarkets?

    a. Bring prescriptions, vision products, eligible OTCs and other purchases to the register at checkout to let the clerk ring them up. (Please note: The list of eligible OTC items changed per the Patient Protection and Affordable Care Act of 2010. Contact your Plan Administrator for more information.)

    b. Present the card and swipe it for payment.

    c. If the card swipe transaction is approved (e.g., there are sufficient funds in the account and at least some of the products are FSA/HRA-eligible), the amount of the FSA/HRA-eligible purchases is deducted from the account balance and no receipt follow up is required. The clerk will then ask for another form of payment for the non-FSA/HRA-eligible items.

    d. If the card swipe transaction is declined, the clerk will ask for another form of payment for the total amount of the purchase.

    e. The receipt will identify the FSA/HRA-eligible items and may also show a subtotal of the FSA/HRA- eligible purchases.

    f. In most cases, the participant will not receive requests for receipts for FSA/HRA-eligible purchases made in participating pharmacies, discount stores, department stores, or supermarkets.

5. Why do participants need to save all of their itemized receipts?
   Participants and their other eligible users should always save itemized receipts for FSA and HRA purchases made with the Prepaid Benefits Card. They may be asked to submit receipts to verify that their expenses comply with IRS guidelines. Each receipt must show: the merchant or provider name, the service received, or the item purchased, the date and the amount of the purchase. The IRS requires that every card transaction must be substantiated. This can occur through automated processing as outlined by the IRS (e.g., copay matching, etc.). If the automated processing is unable to substantiate a transaction, the IRS requires that itemized receipts must be submitted to validate expense eligibility.

6. How long do participants need to save their itemized receipts?
   Participants should save itemized receipts for FSA and HRA until the end of the plan year and/or grace period (if applicable). HSA participants should save receipts for three years to comply with IRS document retention rules.

7. What if participants lose their receipts or accidentally swipe the card for something that's not eligible?
   Usually, the service provider can recreate an account history and provide a replacement receipt. If a receipt cannot be located, recreated, or if the expense is ineligible for reimbursement, the participant can send a check or money order to the Plan Administrator for the amount so it can be credited back to the participant's FSA/HRA account.

8. May participants use the Prepaid Benefits Card for prescriptions ordered prior to activating the card?
   No. The card must be activated prior to the order and/or purchase date of prescriptions. In some cases, participants need to wait one business day after activating the card to purchase prescriptions at their pharmacy. For example, if the card is activated on Tuesday, a prescription can be ordered and picked up on Wednesday.

9. May participants use the Prepaid Benefits Card if they receive a statement with a Patient Due Balance for a medical service?
   Yes. If they have money in their account for the balance due, the services were incurred during the current plan year, and the provider accepts Mastercard® debit cards or Visa® debit cards, participants can simply write the card number on their statement and send it back to the provider.

10. Sometimes the participant is asked for the CVV when paying the balance due or when placing an order by phone or online. What is this and where is it found?
    CVV stands for "Card Verification Value." It is a 3-digit number that can be found on the back of the card to the right of the signature panel.

11. How do participants know how much is in their account?
    They can visit their personal Account Summary page at www.isolvedbenefitservices.com and view their account activity and current balance. Or they can call isolved at 866-370-3040 or via email, fsa@isolvedhcm.com to obtain their current balance. Participants should always know their account balance before making a purchase with the card.

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12. What if participants have an expense that is more than the amount left in their account?
By checking their account balance often – either online or by calling isolved at 866-370-3040 or via email, fsa@isolvedhcm.com – participants will have a good idea of how much is available. When incurring an expense that is greater than the amount remaining in their account, participants may be able to split the cost at the register. (Check with the merchant.) For example, participants may tell the clerk to use the Prepaid Benefits Card for the exact amount left in the account, and then pay the remaining balance separately. Alternatively, participants may pay by another means and submit the eligible transaction manually via a claim form with the appropriate documentation to their Plan Administrator.

13. What are some reasons that the Prepaid Benefits Card might not work at point of sale?
The most common reasons why a card may be declined at the point of sale are:

    a. The card has not been activated.

    b. The card has been used before the 24-hour period after activation is over.

    c. The participant has insufficient funds in his or her employee benefit account to cover the expense.

    d. Non-eligible expenses have been included at the point-of-sale. (Retry the transaction with the eligible expense only.)

    e. The merchant is encountering problems (e.g., coding or swipe box issues).

    f. The pharmacy, discount store, department store, or supermarket cannot identify FSA/HRA-eligible items at checkout according to IRS rules.

14. Is the participant responsible for charges on lost or stolen Prepaid Benefits Cards?
If isolved and the issuing bank are notified within two business days, the participant will not be responsible for any charges. If the notification is after two days, the participant may be responsible for the first $50 or more. Replacement cards may be purchased.

15. Whom do participants call if they have questions about the Prepaid Benefits Card?
Contact isolved at 866-370-3040 or via email, fsa@isolvedhcm.com.

16. How will a participant know to submit receipts to verify a charge?
The participant will receive a letter or notification from isolved if there is a need to submit a receipt. All receipts should be saved per the IRS regulations.

17. What if a participant fails to submit receipts to verify a charge?
If receipts are not submitted as requested to verify a charge made with Prepaid Benefits Card, then the card may be suspended until receipts are received. The participant may be required to repay the amount charged. The Plan Administrator will advise the participant that the card has been suspended, if a receipt is not received. Submitting a receipt or repaying the amount in question will allow the card to become active again.

Prepaid Benefits Card FAQ

What is the Prepaid Benefits Card?

The Prepaid Benefits Card is a special-purpose MasterCard® card that gives participants an easy, automatic way to pay for eligible health care/benefit expenses. The card lets participants electronically access the pre-tax amounts set aside in their respective employee benefits accounts such as Flexible Spending Accounts (FSAs), Health Reimbursement Accounts (HRAs) and Health Savings Accounts (HSAs).



How does the Benefits Card work?

It works like a MasterCard® card, with the value of your account(s) contribution stored on it. When you have eligible expenses at a business that accepts MasterCard® debit cards, you simply use the card. The amount of the eligible purchase will be automatically deducted from your account and the pre-tax dollars will be electronically transferred to the provider/merchant for immediate payment.

Does the Benefits Card change how the participant is reimbursed for expenses?

Before the Benefits Card became available, you had to pay for eligible expenses at the time of purchase, submit claim forms along with all receipts, and then wait for the reimbursement to be processed. Checks were issued and mailed to you. In theory, you paid twice – through payroll deduction and then at the point of sale – then you had to wait for reimbursement.

With the Benefits Card, you simply swipe your card and the funds are automatically deducted from your respective benefit account(s) for payment. The card eliminates most out-of-pocket cash outlays and paperwork, as well as the need to wait for reimbursement checks.

Is the Benefits Card just like other MasterCard® cards?

No. The Benefits Card is a special-purpose MasterCard® card that can be used only for eligible health care/benefits expenses. It cannot be used, for instance, at gas stations or restaurants. There are no monthly bills and no interest.

How many Benefits Cards will you receive?

You will receive two cards. If you would like additional cards for other family members, please contact isolved Benefit Services.

Will you receive a new Benefits Card each year?

No, you will not receive a new card each year. If your card was used in the current benefit year and you will have a benefit associated with the card for the following plan year, simply keep using the same card the following year. The card will be loaded with the new annual election amount at the start of each plan year or incrementally with each pay period, based on the type of account(s) you have.

What if the Benefits Card is lost or stolen?

You should call isolved Benefit Services to report a lost or stolen card as soon as you realize it is missing, so the card can be turned off and a replacement issued. There may be a fee for replacement cards.

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isolved Benefit Services

Prepaid Benefits Card FAQ

Getting Started and Activating Your Card

How do I activate the Card?

You should call the toll-free number on the activation sticker on the front of the card or visit the website on the back of the card. You can use both cards once the first card is activated, you do not need to activate both. You should wait one business day after activation to use the card. Each card user should sign the card with their name.

What dollar amount is on the Benefits Card when it is activated?

For Health Care FSAs, the dollar value on the card will be the annual amount that you elected to contribute to your respective employee benefit account(s) during benefits enrollment. Eligible expenses will be deducted from that total dollar amount as the card is used or manual claims are submitted.

Some other types of accounts, like Dependent Care FSAs, HRAs and transportation accounts, are funded incrementally at each pay period, so it is especially important to be aware of account balances in order to avoid card declines at the point of service.

Using the Card

Where can you use the Benefits Card?

IRS regulations allow you to use the Benefits Cards in participating pharmacies, mail-order pharmacies, discount stores, department stores and supermarkets that can identify FSA/HRA eligible items at checkout and accept MasterCard® prepaid cards. Eligible expenses are deducted from the account balance at the point of sale. Transactions are fully substantiated, and in most cases no paper follow-up is needed. You can find out which merchants are participating by visiting the website on the back of the card.

Some plan designs may also allow you to use the cards in pharmacies that have certified that 90% of the merchandise they sell is FSA/HRA eligible. However, since these pharmacies cannot identify the eligible items at the point of sale, another form of auto substantiation or paper follow-up will be required.

You may also use the card to pay a hospital, doctor, dentist or vision provider that accepts MasterCard®. In this case, auto-substantiation technology is used to electronically verify the transaction's eligibility according to IRS rules. If the transaction cannot be auto substantiated, follow-up will be required.

Are there places the Benefits Card won't be accepted?

Yes. The card will not be accepted at locations that do not offer the eligible goods and services, such as hardware stores, restaurants, bookstores, gas stations and home improvement stores.

Cards will not be accepted at pharmacies, mail-order pharmacies, discount stores, department stores and supermarkets that **cannot** identify FSA/HRA eligible items at checkout. The card transaction may be declined. You can find out which merchants are participating by visiting the website on the back of the card.

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Prepaid Benefits Card FAQ

If asked, should you select *debit* or *credit*?

Your Benefits Card is actually a prepaid card. But, since there is no prepaid selection available, you should select credit. You do not need a PIN and cannot get cash with the prepaid Benefits Card.

How does the card work in participating pharmacies, discount stores, department stores and supermarkets?

a. Bring prescriptions, vision products, eligible OTC and other purchases to the register for checkout. (Please note: The list of eligible OTC items changed per the Patient Protection and Affordable Care Act of 2010.)
b. Swipe the card for payment.
c. If the card swipe transaction is approved (e.g., there are sufficient funds in the account and at least some of the products are FSA/HRA eligible), the amount of the FSA/HRA eligible purchase is deducted from the account balance and no receipt follow up is required. You will be asked for another form of payment for the non-FSA/HRA eligible items.
d. If the card swipe transaction is declined, you will be asked for another form of payment for the total amount of the purchase.
e. The receipt will identify the FSA/HRA eligible items and may also show a subtotal of the FSA/HRA eligible purchases.
f. In most cases, you will not receive requests for receipts for FSA/HRA eligible purchases made in participating pharmacies, discount stores, department stores or supermarkets.

Why do you need to save all of their itemized receipts?

You and your other eligible users should always save itemized receipts for FSA and HRA purchases made with the Benefits Card. You may be asked to submit receipts to verify that the expenses comply with IRS guidelines. Each receipt must show: the merchant or provider name, the service received or the item purchased, the date and the amount of the purchase. The IRS requires that every card transaction must be substantiated. This can occur through automated processing as outlined by the IRS (e.g., co-pay matching, etc.). If the automated processing is unable to substantiate a transaction, the IRS requires that itemized receipts must be submitted in order to validate expense eligibility.

How long do you need to save their itemized receipts?

Participants should save itemized receipts for FSA and HRA until the end of the benefit year and/or grace period (if applicable). HSA participants should save receipts for three years to comply with IRS document retention rules.

What if you lose receipts or accidentally swipe the card for something that's not eligible?

Usually the service provider can provide a replacement receipt. In the event that a receipt cannot be located, recreated or if the expense is ineligible for reimbursement, the participant can send a check or money order to isolved Benefit Services for the amount so it can be credited back to the FSA/HRA account.

May you use the Benefits Card for prescriptions ordered prior to activating the card?

No. The card must be activated prior to the order and/or purchase date of prescriptions. In some cases, participants need to wait one business day after activating the card to make purchases. For example, if the card is activated on Tuesday, a prescription can be ordered and picked up on Wednesday.

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isolved Benefit Services

Prepaid Benefits Card FAQ

Can you use the Benefits Card if you receive a statement with a patient due balance for a medical service?

Yes. As long as you have money in your account for the balance due, the services were incurred during the current plan year and the provider accepts MasterCard® debit cards, you can simply write the card number on the statement and send it back to the provider.

Sometimes you are asked for the CVV when paying the balance due or when placing an order by phone or online. What is this and where is it found?

CVV stands for Card Verification Value. It is a three-digit number that can be found on the back of the card to the right of the signature panel.

How do you know how much is in your account?

You can visit your personal Account Summary page or the mobile app to view account activity and current balance. Participants should always know their account balance before making a purchase with the card.

What if you have an expense that is more than the amount left in your account?

By checking the account balance often – either online or via the mobile app – you will have a good idea of how much is available. When incurring an expense that is greater than the amount remaining in your account, you may be able to split the cost at the register (check with the merchant). For example, participants may use the Benefits Card for the exact amount left in the account, and then pay the remaining balance separately. Alternatively, you may pay by another means and submit the eligible transaction via a claim form online or via the mobile app with the appropriate documentation.

What are some reasons that the Benefits Card might not work at point of sale?

The most common reasons why a card may be declined at the point of sale are:

a. The card has not been activated.
b. The card has been used before the 24-hour period after activation is over.
c. You have insufficient funds in your employee benefit account to cover the expense.
d. Noneligible expenses have been included at the point of sale. (Retry the transaction with the eligible expense only.)
e. The merchant is encountering problems (e.g. coding or swipe box issues).
f. The pharmacy, discount store, department store or supermarket cannot identify FSA/HRA eligible items at checkout according to IRS rules.

Are you responsible for charges on lost or stolen Benefits Cards?

If isolved Benefit Services is notified within two business days, you will not be responsible for any charges. If the notification is after two days, you may be responsible for the first $50 or more. Replacement cards may be purchased.

Whom do you call if they have questions about the Benefits Card?

Call isolved Benefit Services at the phone number shown on the back of the card.

Can you use the Benefits Card to access last year's money left in the account this year?

The IRS allows for a grace period in the current year to use up funds carried over from the prior year. Contact isolved Benefit Services to find out how the grace period is handled for your specific program.

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Prepaid Benefits Card FAQ

How will you know to submit receipts to verify a charge?

You will receive a letter or notification from isolved Benefit Services if there is a need to submit a receipt. All receipts should be saved per the IRS regulations.

What if you fail to submit receipts to verify a charge?

If receipts are not submitted as requested to verify a charge made with Benefits Card, then the card may be suspended until receipts are received. You may be required to repay the amount charged. isolved Benefit Services will advise you that the card has been suspended, if a receipt is not received. Submitting a receipt or repaying the amount in question will allow the card to become active again.

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Flexible Spending Accounts.

Real Savings. Real Simple.

Using a Flexible Spending Account (FSA) is a great way to stretch your benefit dollars. You use pre-tax dollars in your FSA to reimburse yourself for eligible out-of-pocket medical and dependent care expenses. That means you can enjoy tax savings with the convenience of a prepaid benefits card. And that makes real sense.

What is an FSA?

With an FSA, you elect to have your annual contribution (up to the annual limit set by the IRS) deducted from your paycheck each pay period in equal installments throughout the year. The amount of your pay that goes into an FSA will not count as taxable income, so you will have immediate tax savings. FSA dollars can be used during the plan year to pay for qualified expenses and services. Please check with your employer to see what plans are offered.

A Health FSA allows reimbursement of qualifying out-of-pocket medical expenses.

A Dependent Care FSA allows reimbursement of dependent care expenses, such as day care, incurred by eligible dependents.

A Limited Purpose Health FSA is compatible with a Health Savings Account (HSA). A limited FSA only allows reimbursement for preventive care, vision and dental expenses, keeping the employee eligible to contribute to an HSA.

With all FSA account types, you'll receive access to a secure, easy-to-use web portal where you can track your account balance, view your investment accounts and submit requests for reimbursements.

In addition, your plan might offer a convenient prepaid benefits card to make it easy to pay for eligible services and products. When you use the card, payments are automatically withdrawn from your account, so there are no out-of-pocket costs and you likely won't have to submit receipts to verify the purchase. Just swipe the card and go. **It's that easy!**

Throughout the year, you'll likely incur expenses for yourself and your family that insurance won't cover. By taking advantage of a health care FSA, you can actually reduce your taxable income and reduce your out-of-pocket expenses when you use your FSA to pay for health care services and products you'd purchase anyway.

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Is an FSA right for me?

An FSA is a great way to pay for expenses with pre-tax dollars. A Health Care FSA could save you money if you or your dependents:

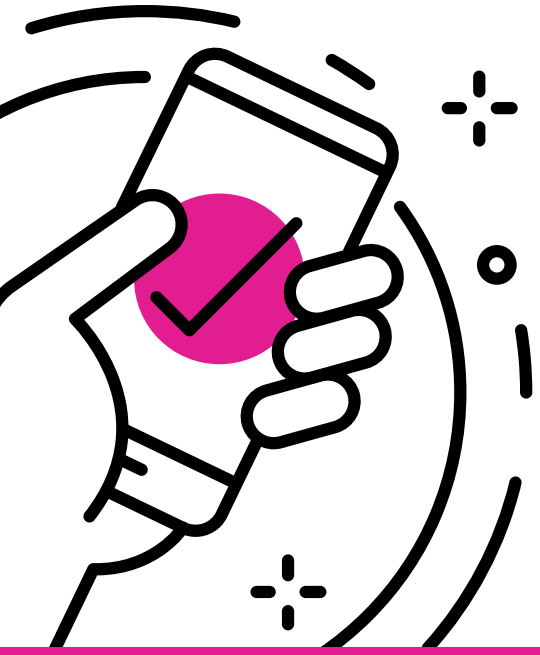
- Have out-of-pocket expenses like **co-pays, coinsurance, or deductibles** for health, prescription, dental or vision plans
- Have a **health condition that requires the purchase of prescription medications** on an ongoing basis
- Wear **glasses or contact lenses** or are planning **LASIK surgery**
- Need **orthodontia care, such as braces,** or have dental expenses not covered by your insurance

A Dependent Care FSA provides pre-tax reimbursement of out-of-pocket expenses related to dependent care. This benefit may make sense if you (and your spouse, if married) are working or in school, and:

- Your **dependent children under age 13 attend day care, after-school care** or **summer day camp**
- You **provide care for a person of any age who you claim as a dependent on your federal income tax return** and who is mentally or physically incapable of caring for himself or herself

An FSA is a great way to pay for expenses with pre-tax dollars.

- Enjoy significant tax savings with pre-tax contributions and tax-free distributions used for qualified plan expenses
- Quickly and easily access funds using the prepaid benefits card at point of sale, or request to have funds directly deposited to your bank account via online or mobile app
- Reduce filing hassles and paperwork by using your prepaid benefits card
- Enjoy secure access to accounts using a convenient Consumer Portal available 24/7/365
- Manage your FSA "on the go" with an easy-to-use mobile app
- File claims easily online (when required) and let the system determine approval based on eligibility and availability of funds
- Stay up to date on balances and action required with automated email alert and convenient portal and mobile home page messages
- Get one-click answers to benefits questions



With the convenience of a mobile device, you can see your available balance anywhere, anytime, as well as file claims and upload receipts.

Plan Ahead

Before you enroll, you must first decide how much you want to contribute to your account(s). You will want to spend some time estimating your anticipated eligible medical and dependent care expenses for the calendar year.

The U.S. Treasury Department modified its Health Flexible Spending Account (FSA) Use-or-Lose rule to allow up to a speficied carryover of Health FSA funds. The carryover option is based solely on your employer's plan design. Not every company allows a carryover. Some employer plans may establish a lower maximum limit than allowed, but it must be uniformly applied to all eligible participants. The carryover is applicable only to Health FSAs (not to Dependent Care FSAs). Any unused amount above the carryover limit is subject to forfeiture and cannot be cashed out or transferred to other taxable or nontaxable benefits (e.g., HSAs). Please review our guide - Contribution Limits - for the carryover amount maximum allowed for each plan year.

For questions, contact us at: **FSA@isolvedhcm.com** or **800-300-3838**

Transforming employee experience for a better today and a better tomorrow.

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Dependent Care FSA

FAQ's

A Dependent Care FSA provides pre-tax reimbursement of out-of-pocket expenses related to dependent care. It's a great option for employees who have dependent children under the age of 13 who attend day care, after-school care or summer day camp, and/or provide care for a person of any age who is claimed as a dependent on the federal income tax return and who is mentally or physically incapable of caring for himself or herself.

Who is a qualified dependent under the Dependent Care FSA?

- Dependent under the age of 13
- Dependent or spouse of employee who is mentally or physically disabled and whom the employee claims as a dependent on their federal income tax return

Can an adult be a qualified dependent?

Yes, an adult may qualify as a dependent provided that the employee is providing more than half of that individual's support for the year and the dependent lives with the employee.

Do I have to use a day care facility?

No. You can be reimbursed for expenses of an individual providing care for your dependent in your home as long as the expenses are incurred for you and your spouse (if married), to work, look for work or attend school full time.

Does my day care provider have to be licensed?

No. However, you are required to submit their Tax Identification Number or Social Security Number when filing your federal income tax return.

My child attends camp during the summer. Is this eligible?

Generally, no. However, if the camp is a day camp and your dependent attends to allow you and your spouse (if married) to work, look for work or attend school full time, then yes, this would be an eligible expense. Overnight camps are specifically excluded.

Does my day care provider have to be 18?

No, but the individual must claim the money as income on their tax return.

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When can I be reimbursed for dependent day care expenses?

Expenses are eligible for reimbursement when they have been incurred, not when you are billed or when you pay for the services.

Example: Your day care provider requires you to pay for the month of September on September 1. You can be reimbursed as the services are incurred, not when you paid for the services. You can submit claims after each week, every week or on October 1.

What support documentation must I file with each Dependent Care claim?

Complete the Dependent Care section of the Request for Reimbursement Form and have your day care provider sign and date. The receipt must include the following information:

- Name and address of provider
- From/through dates of service
- Amount of charge

Can I submit claims for dependent care expenses that are greater than the current balance of my Dependent Care FSA?

Yes. However, you will only receive reimbursement for the amount that you have contributed to your Dependent Care FSA. For example, if you contribute $150 each month to your Dependent Care FSA, then you will only receive $150 in reimbursement each month. The excess amount of expenses will be pended and automatically paid to you as contributions are posted to your account.

What happens if a claim exceeds the amount currently available in my Dependent Care FSA?

The claim will be processed and approved. The amount that is currently available will be disbursed and the remaining portion will be pended until you make another contribution.

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Basic Life and AD&D Insurance



Basic Life Insurance

Life insurance provides financial protection for your family in the event of your death. HACAP offers all employees life and accidental death and dismemberment insurance through The Hartford with an issue amount of $25,000. HACAP covers the cost of this benefit.

Your benefit amount will reduce by 45% at age 70.

Plan Cost: 100% Employer Paid

Voluntary Life Insurance

Increase Your Coverage

You may elect to increase your life insurance coverage for yourself, your spouse and your dependent children – all at an affordable group rate provided by The Hartford. This coverage comes in the following increments:

Employee Voluntary Life

Benefit Amount: increments of $10,000
Non-Medical Maximum Benefit: $200,000
Maximum Benefit: $500,000

Spousal Voluntary Life

Benefit Amount: increments of $5,000
Non-Medical Maximum Benefit: $30,000
Maximum Benefit: $100,000
Spouse amount cannot exceed 100% of the employee's Supplemental Life benefit.

Dependent Child Voluntary Life

Benefit Amount: increments of $2,000
Non-Medical Maximum Benefit: $10,000
Maximum Benefit: $10,000

Portability Options for Basic & Voluntary Life

If your coverage under the Policy ends prior to age 70, for any of the following reasons:

a. termination of employment; or
b. termination of membership in an eligible class under the Policy;
c. Conversion and portability are not available for AD&D coverage.

Life Insurance Benefits may be continued up to the Maximum Benefit shown in the Schedule of Benefits for this option.

You must apply to the Insurance Company and pay the required premium. If you continue coverage, coverage for your Spouse or Dependent Child may also be continued by you. Your Spouse or Dependent Child must be covered under the Policy on the date coverage would otherwise end. The application must be submitted:

a. within 31 days of your termination of employment or membership in an eligible class under the Policy; or
b. during the time that you have to exercise the Conversion Privilege.

Coverage under this option may not be elected at a later date.

Short-Term Disability



To ensure your income will continue if you are unable to work due to a disability that extends for more than 7 consecutive days, HACAP provides short-term disability (STD) after completing 12 months of employment. Benefits are payable for a non-occupational injury or illness that keep you from performing the normal duties of your job. If a medical condition is job-related, it is considered Workers' Compensation rather than STD.

Benefits Start: On the 8th day
Benefit Amount: 60% of basic weekly earnings up to $1,800 / week
Benefit Duration: 25 weeks

Plan Cost: 100% Employer Paid

Voluntary Long-Term Disability

Voluntary Long-Term Disability (LTD) insurance helps replace a portion of your income for an extended period of time. Eligibility for long-term benefits is generally defined as if, due to sickness, pregnancy or accidental injury, you are receiving appropriate care and treatment and are complying with the requirements of the treatment and you are unable to earn more than 80% of your pre-disability earnings at your own occupation for any employer in your local economy.

Benefits Start After: 180 days
Benefit Amount: 60% of pre-disability monthly earnings
Maximum Benefit: $3,000 per month
Benefit Duration: The later of your SSNRA* or the Maximum Benefit Period.

**SSNRA means the Social Security Normal Retirement Age in effect under the Social Security Act on the Policy Effective Date.*

Pre-Existing Condition Limitations

The carrier will not pay benefits for any period of Disability caused or contributed to by, or resulting from, a Pre-existing Condition. A "Pre-existing Condition" means any Injury or Sickness for which you incurred expenses, received medical treatment, care or services including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 3 months before your most recent effective date of insurance.

The Pre-existing Condition Limitation will apply to any added benefits or increases in benefits. This limitation will not apply to a period of Disability that begins after you are covered for at least 12 months after your most recent effective date of insurance, or the effective date of any added or increased benefits.

Plan Cost: 100% *EMPLOYEE* Paid

Voluntary Critical Illness

Plan Cost: 100% Employee Paid

Critical illness insurance may help you cover expense not covered by your health insurance.

It's a cash payment you receive if you ever experience a serious illness like cancer, a heart attack, or a stroke, giving you the financial support to focus on recovery.

Who is it for?

Critical illness insurance is a supplemental policy for people who already have health insurance. It provides you with an additional payment to cover expenses like deductibles, treatments, and living costs.

What does it cover?

Critical illness includes strokes, heart attacks, Parkinson's disease and cancer. Our policies can cover over 30 major illness, helping you stay financially stable by paying you a lump sum if you're diagnosed with one of them.

Why should I consider it?

Health coverage may be become more expensive, with higher co-pays, premiums, and deductibles. Critical illness insurance is an affordable way to help supplement and pay for additional expenses that your health insurance doesn't cover. Our policies typically provide payments for the first and second time you're diagnosed with a covered illness.

Critical illness insurance is portable, and payments are made directly to you.



CRITICAL COSTS

John is hospitalized after a heart attack and has to cover the cost of five days as an inpatient.

Average heart attack hospitalization expense: **$53,000**

Average Major Medical deductible: **$1,500**

Major Medical covers 80% of the cost after the deductible is met, but John's still responsible for 20%: **$10,300**

Total out-of-pocket amount for John (deductible + coinsurance): **$11,800**

John has a $10,000 Guardian Critical Illness policy, which covers the majority of these out-of-pocket expenses.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information for specific amounts and details.

You will receive these benefits if you meet the conditions listed in the policy. Monthly premiums (election cost per age bracket):

Employee		< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
$10,000	Non-Tobacco	$11.60	$11.60	$22.30	$22.60	$22.60	$43.40	$44.20	$68.20	$100.50	$102.30
	Tobacco	$16.20	$16.20	$34.80	$35.20	$35.20	$70.10	$71.50	$103.30	$153.60	$156.40
$20,000	Non-Tobacco	$23.20	$23.20	$44.60	$45.20	$45.20	$86.80	$88.40	$136.40	$201.00	$204.60
	Tobacco	$32.40	$32.40	$69.60	$70.40	$70.40	$140.20	$143.00	$206.60	$307.20	$312.80
Spouse		**< 30**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**	**70+**
$5,000	Non-Tobacco	$5.80	$5.80	$11.15	$11.30	$11.30	$21.70	$22.10	$34.10	$50.25	$51.15
	Tobacco	$8.10	$8.10	$17.40	$17.60	$17.60	$35.05	$35.75	$51.65	$76.80	$78.20
$10,000	Non-Tobacco	$11.60	$11.60	$22.30	$22.60	$22.60	$43.40	$44.20	$68.20	$100.50	$102.30
	Tobacco	$16.20	$16.20	$34.80	$35.20	$35.20	$70.10	$71.50	$103.30	$153.60	$156.40

Voluntary Accident

Plan Cost: 100% Employee Paid

Accidents happen. With accident insurance, you can help them hurt a bit less.

Accident insurance is an extra layer of protection that gives you a cash payment to help cover out-of-pocket expenses when you suffer an unexpected, qualifying accident.

Who is it for?

Nobody can predict when an accident might happen. That's why accident insurance is an important add-on policy for people who want to supplement the health and disability insurance coverage they already have individually or through an employer.

What does it cover?

Accident insurance pays you lump sum benefits after an accident happens. This could be a severe burn, broken bone or emergency room visit. Our accident insurance policies also offer an increased benefit that pays extra for children injured while playing an organized sport like soccer, baseball, lacrosse, or football.

The child must be covered at the time the accident occurred and be 18 years of age or younger.

Why should I consider it?

Health coverage may be become more expensive, with higher co-pays, premiums, and deductibles. Accident insurance can be a simple, affordable way to help supplement and cover additional expenses your health and disability insurance may not cover, including x-rays, ambulance services, deductibles, and even things like rent or groceries.

Accident insurance is portable, and payments are made directly to you.

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



ADDED SUPPORT DURING RECOVERY

Amanda breaks her leg falling off her bike and needs emergency treatment.

Average non-surgical broken leg treatment expense: **$2,500**

Average Major Medical deductible: **$1,500**

Major Medical covers 80% of the surgical cost after the deductible is met, but Amanda's still responsible for 20%: **$200**

Total out-of-pocket amount for Amanda (deductible + coinsurance): **$1,700**

Amanda's Guardian Accident policy pays her a benefit of **$1,700**, which covers all her out-of-pocket expenses.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information for specific amounts and details.

Coverage Details	Option I: Value	Option 2: Advantage
Your Monthly Premium	$7.50	$15.38
You and Spouse	$12.96	$26.60
You and Child(ren)	$15.82	$33.00
You, Spouse and Child(ren)	$21.28	$33.00
Accident Coverage Type	On and Off Job	On and Off Job
Portability – allows you to take your Accident coverage with you if you terminate employment	Included	Included
Accidental Death & Dismemberment		
Employee	$25,000	$50,000
Spouse	$10,000	$25,000
Child	$5,000	$10,000

Need to File a Claim? We're Here to Help.

Your Dedicated bherd Claims Support Team

Filing a Hawkeye Area Community Action Program claim doesn't have to feel overwhelming. Bherd provides a dedicated claims support team whose only job is to make the process easier for you.

- **Claim support from the very beginning** – We'll explain how to initiate your claim and then help you navigate the process through completion.
- **Track your claim** – We'll stay on top of your claim's progress so nothing falls through the cracks.
- **Help with paperwork** – With your permission, we can even gather medical records on your behalf.
- **Double-check payments** – When your benefit is approved, we'll review it for accuracy.

■ For Short Term Disability claims, The Hartford requires you to initiate the claim directly. This means you will need to call 1-888-277-4767 to begin the process. The Hartford will ask for basic information about you, your employer, your last day worked, your physician, and the nature of your claim.

■ Once your claim has been opened, our bherd Claims Support Team can step in to help. We can answer questions, assist with paperwork, help gather information or medical records with your permission, track the claim, and review the benefit decision and payment for accuracy.

Contact Us:

■ support@thebherd.com
■ 515-393-2303



FILE A CLAIM WITH CONFIDENCE

HAWKEYE AREA COMMUNITY
ACTION PROGRAM, INC.

922101

FILE YOUR CLAIM TODAY

Your disability program is managed by The Hartford.

THE HARTFORD MAKES IT EASY TO FILE A CLAIM

Step 1: Know when it's time to take action.

If you're absent from work, we can advise you on when to file a claim. If your absence is scheduled, such as an upcoming hospital stay, call us 30 days prior to your last day of work. If unscheduled, please call us as soon as possible.

Step 2: Have this information ready.

- Name, address and other key identification information.
- Name of your department and last full day of active work.
- The nature of your claim.
- Your treating physician's name, address, phone and fax numbers.

Step 3: Make the call or file online. With your information handy, call The Hartford at 888-277-4767

You'll be assisted by a caring professional who'll take your information, answer your questions and file your claim.

TO FILE A CLAIM

888-277-4767

922101

If you're absent from work, we can advise you on when to file a claim. If your absence is scheduled, such as an upcoming hospital stay, call us 30 days prior to your last day of work. If unscheduled, please call us as soon as possible.

THE HARTFORD

continued

THE HARTFORD



GET SUPPORTIVE ASSISTANCE

Even after your claim has been filed we may be in touch to check your progress, answer questions or obtain additional information from you. Our goal is to offer a smooth and hassle-free experience until you return to work. Feel free to also call us with anything that's on your mind. We're here to help.

RELAX AND STAY POSITIVE

You have the assurance of our knowledge, experience and understanding of what you're going through. We're with you all the way, so you can receive the benefits you qualify for and get back to your life.

QUICK FACTS

The Hartford's goal is to help get you through your time away from work with dignity and assist you in any way we can. Keep the card below in a safe place for future use. We'll be there when you need us.

TheHartford.com/groupbenefits

THE HARTFORD

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Disability Form Series includes GBD-1000, GBD-1200, or state equivalent.

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(Please cut here and keep in your wallet.)

WHEN YOU CALL THE HARTFORD WILL ASK YOU TO PROVIDE:

- Name, address and other key identification information.
- Name of your department and last full day of active work.
- The nature of your claim.
- Your treating physician's name, address, phone and fax numbers.

This card is not proof of insurance.

HOW TO SUBMIT A CLAIM FOR CRITICAL ILLNESS, ACCIDENT AND HOSPITAL INDEMNITY INSURANCE

Experiencing an illness, accident and/or a hospital stay can be challenging. Now you need to file a claim, and the process may seem overwhelming. But The Hartford is here to make this as easy as possible.

REFERENCE THE ACTION STEPS AND RESOURCES BELOW TO HELP YOU WITH YOUR CLAIM.

ACTION	
When should a claim be filed?	**Critical Illness**[1] • After a physician has diagnosed you or a covered dependent with a covered illness. • After you or a covered dependent have undergone a health screening and are eligible for a wellness or health screening benefit.
	Accident • After you or your covered dependents receive services performed as a result of an accident. • After you or a covered dependent have undergone a health screening and are eligible for a wellness or health screening benefit.
	Hospital Indemnity • After you or a covered dependent have had a hospital stay as the result of a covered illness or injury. • After you or a covered dependent receive services performed as a result of a covered illness or injury (if included in the policy). • After you or your dependent have undergone a health screening and are eligible for a wellness or health screening benefit.
Who can file a claim and how?	Anyone insured under the policy, or an authorized representative, can file a claim at any time, from anywhere. You can file your claim in different ways depending on what's most convenient to you: **1. ONLINE** • Visit the Supplemental Insurance Claims Portal at **TheHartford.com/benefits/myclaim**. • Register for access if you have not done so already. (Please note: We must have current eligibility from your benefits administrator for you and any dependents to be eligible to register on the portal.) • Log in to the portal. • Click on **"Complete Your Claim Form Online"** under the Quick Links section. • Follow the prompts to complete and submit a claim. **2. FILE A CLAIM OVER THE PHONE** (Applicable to Health Screening Benefit/Accident Protection Benefit Only) • File your claim by calling **866-547-4205**. • Available Monday through Friday, 8:00 a.m. – 6:00 p.m. EST. **3. SUBMIT A CLAIM VIA MAIL OR FAX** • Download a claim form at **TheHartford.com/benefits/myclaim**. • Complete the form and mail or fax it to: The Hartford Supplemental Insurance Benefit Department P.O. Box 99906 Grapevine, TX 76099 Fax Number: 469-417-1952 For assistance filing your claim, call **866-547-4205**.

THE HARTFORD

ACTION	
What information will you need to provide when submitting your claim?	• The form will ask you to provide some information about you, and if you're filing the claim for a dependent, their information as well. • Then, select which type of claim you're filing. Continue through the form, only filling out the relevant sections. • In the Benefit Information section, check off each box that applies to the event or services you received as a result of your covered illness and/or accident and/or hospital stay. • Be sure you sign the Authorization to Obtain and Disclose Information (which helps us obtain information for the claim from medical providers, if needed) and sign the claim form itself. In addition to filling out the form, you'll also need to provide supporting documentation to prove the claim. **Examples of documents include:** ER, urgent care, physician visit or hospital discharge papers; exam, lab or test results/reports; physician notes; Explanation of Benefits (EOBs) from your health insurance provider; itemized medical or hospital bills; or medical records. Please call us for guidance with your claim submission – we're happy to help you understand how to complete the claim successfully. By thoroughly completing the form and gathering your documentation, we'll be able to better serve you and ensure your claim is processed as quickly as possible. We may also need to work with medical providers to fully prove your claim, but we'll let you know during the claims process if this is necessary.
What happens next?	After you submit your claim, our dedicated claims team will review the claim and contact you with any questions or to request additional information needed for your claim. Our goal is to ensure you receive all benefits you're entitled to, as quickly as possible. We will review your total voluntary benefits coverage with The Hartford to determine if you might be eligible for additional benefits based on other insurance policies you've purchased. If you are filing a Critical Illness claim and forgot to tell us about a hospital stay for a Hospital Indemnity claim, for example, we've got you covered. Once the claim has been approved, the standard turnaround time for benefits to be paid is between 3-10 business days.[2] Standard mail times will apply (if applicable). In the meantime, if you filed your claim online, you can use the site to monitor your claim status and access additional claims-related information at **TheHartford.com/benefits/myclaim**. For all claims, you are welcome to call 866-547-4205 for claims status or questions.

TO GET STARTED,

visit **TheHartford.com/benefits/myclaim**

Or contact our Customer Service Center at **866-547-4205** for assistance.

THE HARTFORD

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including underwriting company Hartford Life and Accident Insurance Company. Home Office is Hartford, CT. All benefits are subject to the terms and conditions of the policy. Policies underwritten by the underwriting company listed above detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in force or discontinued. © 2021 The Hartford.

THESE POLICIES PROVIDE LIMITED BENEFITS. These limited benefit plans (1) do not constitute major medical coverage, and (2) do not satisfy the individual mandate of the Affordable Care Act (ACA) because the coverage does not meet the requirements of minimum essential coverage. In New York: The Hospital Indemnity and Critical Illness policies provide limited benefits health insurance only. The Accident policy provides ACCIDENT insurance only. IMPORTANT NOTICE — THE ACCIDENT POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS. These policies do NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services.

Critical Illness Form Series includes GBD-2600, GBD-2700, or state equivalent. Accident Form Series includes GBD-2000, GBD-2300, or state equivalent. Hospital Indemnity Form Series includes GBD-2800, GBD-2900, or state equivalent.

[1] Critical Illness is referred to as "Specified Disease" in New York.

[2] Based on average claims turnaround time.

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Employee Assistance Program

The Employee Assistance Program (EAP) through EFR Employee & Family Resources provides a variety of counseling, consultations, resources, and coaching benefits for you and your family members. Your EAP benefits are cost-free to you, confidential, and available 24/7/365.

Get help with:

- Stress Management
- Relationship Concerns
- Personal Growth
- Anxiety or Depression
- Legal Issues
- Identity Theft
- Tax Questions
- Elder Care
- Financial Concerns
- Budgeting and Debt

Call (800) 327-4692 to Access Your Benefit

When should you call the EAP?

Call **800-327-469**2 whenever you are experiencing one of life's challenges. We are available 24/7/365.

What happens when I call?
A representative from EFR will answer your call. The representative will gather demographic information and help you connect with an EAP counselor.

You will be connected with a masters-level clinician to discuss your issues, concerns, or struggles.

EAP Benefit Summary	Frequency
Phone-Based Support Call any time you have and issue, concern, or question. You have 24/7 access to masters-level clinicians	unlimited
In-Person or Telehealth Counseling Arrange in-person counseling sessions with a licensed mental health therapist near your home or work. Each family member is eligible.	3 sessions per issue per year
Telephonic Life Coaching Speak with a life coach and receive tailored advice on matters involving time management, work-life integration, goal setting, communication skills, and other areas of personal growth.	3 sessions per year
Telephonic Financial Consultation Speak with a financial professional about each separate issue, and access a free financial check-up, financial library, and a variety of other financial tools by visiting efr.org/financial	1 30-min session per issue
In-Person or Telephonic Legal Consultation Meet with a licensed attorney with expertise in your area of need. Visit efr.org/legal for more information regarding retention and self-help legal documents.	1 30-min session per issue
Eldercare Resources Access information, referral resources, and support involving the care for an aging family member.	as needed
Childcare Resources Receive childcare resource referrals where locally available. All referrals are state licensed/ certified childcare providers.	as needed
Additional Benefits Stay up-to-date by reading our monthly newsletter, watching our webinars, and/or completing self-assessments. Visit efr.org for more information.	provided regularly

Employee Assistance Program continued…

What happens when I see the EAP counselor?

- The master's level EAP counselor will listen to your concerns.
- The counselor will also help you explore other areas of your life to assess for strengths and supports, or factors contributing to your presenting issue or concern.
- The counselor will meet with you **up to 3 sessions** to complete a comprehensive assessment of your current circumstances and work with you to establish a plan for EAP sessions.

Options for EAP sessions include:

- Assessment completed and remaining sessions are used for brief counseling and problem resolution.
- Assessment completed and a referral is recommended for services that fall outside the scope of EAP services.

Common Questions

Can I use the EAP more than once a year?
Yes, but each time you use the EAP, the counselor will be assessing your life circumstances so you will be eligible for a new set of 3 sessions if your circumstances have changed, or in 12 months, whichever comes first.

What is a new set of circumstances?
A new development in your life that has changed since your last EAP assessment.

Why can't I use the EAP more often?
EAP is an assessment, referral, and brief counseling model to assist employees with managing a wide variety of personal issues, but is not intended to replace therapy, treatment, or ongoing counseling.



403(b) Retirement Account

HACAP's 403(b) Retirement Savings Plan offers a convenient way to save for your future through payroll deductions.

Eligibility

You are eligible to participate in the plan upon your first day of employment or can enroll anytime thereafter.

Contributions

Employee: Designates the amount of contribution
Employees can change the amount of contributions or terminate participation at any time.
Employer: Up to a maximum of 9.44% for employees 6.29% contribution.
Employee must elect out of IPERS for company contributions to match the 403(b).

Vesting

The Employee directs contributions to available funds.
100% vested in both employee and employer contributions immediately.

For More Information

For additional details about the 403(b) Retirement Savings Plan or to enroll or change your contribution rates or investment elections, please visit www.myprincipal.com/welcome or you may call 1-800-547-7754.

Additional Features

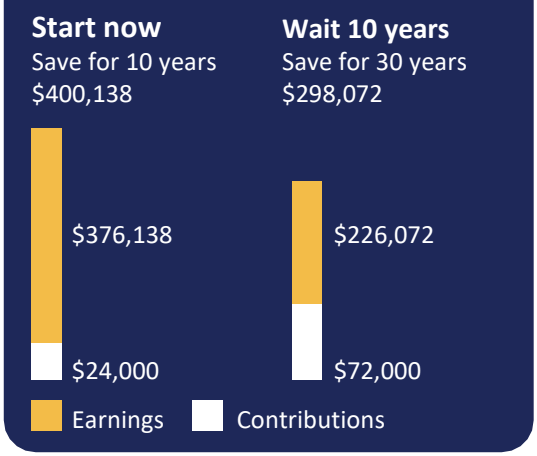
- **A broad range of investment options.** When you decide how to invest your account balance, spreading your savings among different investments can help smooth the ups and downs of market cycles and reduce risk. In deciding how to allocate the investment of your account balance, keep in mind that some of the plan's investment options, known as "target date funds," contain an asset allocation strategy within the investment option itself.
- **Automatic contributions.** If you want to have contributions automatically deducted, your company's plan offers Automatic Enrollment.
- **An account you can take with you.** Should you leave HACAP, your vested balance is yours to take with you.



Starting earlier can pay off

It's important to save enough for your future, and it's also important to understand the concept of compounded returns.
The chart shows how starting earlier puts compounding to work for you over time.

Save $200 a month:



This hypothetical illustration assumes pre-tax contributions made at the beginning of each month and an annual effective rate of return of 8% and reinvestment of earnings.

**Start now assumes the contributions are invested for 40 years;*

***Wait 10 years assumes contributions are invested for 30 years. Results are for illustrative purposes only and are not meant to represent the past or future performance of any specific investment vehicle.*

VESTED MEMBERSHIP

As a vested IPERS member, you have earned access to several benefits.

Benefit Payments

Upon your retirement, you are eligible for monthly retirement benefits or a lump sum benefit amount.

Employer Contributions

You were always entitled to 100% of your own IPERS contributions and interest earnings. As a vested member, if you leave IPERS-covered employment and take a refund, you will also receive a portion of your employers' contributions made on your behalf, plus interest. The employer portion is a percentage of your employer's contributions calculated by dividing your years of service by 30.

Example: Jill leaves IPERS-covered employment after 15 years of service. She may receive 50% of her employer's investment.

15 Years ÷ 30 = 50%

Portability of Benefits

If you leave IPERS-covered employment, you can choose to keep your money in IPERS. This may be helpful if you return to public service. You can also take a refund or roll over all or a portion of your money to a qualified plan such as a 401(k) or an IRA.

THE LONGER YOU WORK, THE LARGER YOUR BENEFIT

Now that you've reached this milestone, you are eligible for retirement benefits. The longer you work in public service, the larger your benefit. For example:

Let's say you have **10 years of service.** Of your five highest-earning years, your average salary is $45,000. If you leave public employment now, at retirement your annual benefit calculation would look like this:

$45,000 Average salary × **20%** Multiplier based on years of service = **$9,000** Annual retirement benefit

If you worked in IPERS-covered employment for **five more years** and left public service with a high five salary average of $52,000, at retirement your annual benefit calculation would look like this:

$52,000 Average salary × **30%** Multiplier based on years of service = **$15,600** Annual retirement benefit

Example is for illustrative purposes only. Your benefit amount will be different and is based on your situation. Early retirement penalties may apply.

Purchasing Service

At retirement, members vested through years of service may "purchase service," which essentially means buying additional quarters of time to increase the amount of your benefit. To learn more about purchasing service, visit www.ipers.org/purchase-service or contact IPERS.

Disability Benefits

Vested members who leave IPERS-covered employment and receive Social Security* disability benefits may qualify for disability benefits from IPERS. Disability benefits allow you to receive benefit payments before you are normally eligible for retirement.

**Includes disability benefits from the U.S. Railroad Retirement Board.*

Death Benefits

IPERS provides death benefits to your designated beneficiaries if you die before you receive IPERS retirement benefits. If you designated one person as your beneficiary, he/she may receive a lump-sum payment or a lifetime monthly benefit. If you selected more than one beneficiary, those beneficiaries will receive a lump-sum payment.

My Account

Connect with us — at your convenience!

www.ipers.org

Before Retirement

- Create estimates of your projected IPERS benefits.
- View a record of your IPERS contributions.

After Retirement

- Change withholding amounts.
- View 1099-R information and other documents.
- See your benefit payment history.

You can also:

- Update your contact information.
- See your designated beneficiary.
- Access records of your IPERS forms and correspondence.

IPERS®

Working Today for Your Tomorrow



Congratulations! You've reached an important milestone: retirement.

This booklet guides you through the steps to begin receiving your IPERS benefit payments. As you embark on this exciting time, we're here to help you.

Your IPERS benefits are only one part of your overall retirement savings. Your total retirement income will come from your IPERS benefits, Social Security, personal savings, and other retirement plans.

Before completing your application for benefits, review this booklet and your benefit estimate. Make sure you understand all the benefit options. If you discover any errors or discrepancies in your estimate, or have any questions, contact IPERS.

The Hawkeye Area Community Action Program, Inc. Welfare Benefit Plan

Notices & Disclosures

for the 2027 Plan Year



Notice of HIPAA Special Enrollment Rights

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

You may also be able to enroll in this plan if coverage is lost under a Medicaid plan or CHIP, or due to a determination of eligibility for a premium assistance subsidy under Medicaid or CHIP. In these events *you must request enrollment within 60 days of the date of a determination of eligibility* for premium assistance or the date the Medicaid or CHIP coverage ends.

Additionally, 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.

Please note that in such cases enrollment is not automatic, and therefore following the enrollment process in its entirety is required, even if it does not change your election tier. So for example, you must formally enroll your newborn child onto the plan within 30 days of the date of birth *even if you already have family coverage and your premiums would not change as a result*. Failing to enroll a dependent would result in that dependent not having coverage even though the coverage for the rest of the family would continue.

Finally, please be advised that this plan reserves the right to require a written reason for declining the offer of coverage. When an enrollment/waiver form is provided for this purpose, a signed and dated letter waiving the coverage and specifying the specific reason for declining the coverage may be accepted by the Plan Administrators.

To request special enrollment or obtain more information, contact Human Resources Department at 319-393-7811 or hresources@hacap.org.

NOTICE: If you or your dependents have Medicare or will become eligible for Medicare in the next 12 months, please see the important notices beginning on Page 6 for important information!

All questions should be directed to:

Human Resources Department
319-393-7811
hresources@hacap.org

Privacy Policy Notice of Availability

Our self-funded dental plan and Flexible Spending Arrangement (FSA) together maintain a *HIPAA Notice of Privacy Practices* (NPP) that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Human Resources Department at 319-393-7811.

Newborns' and Mothers' Health Protection Act 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 a vaginal delivery, or less than 96 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Note that more generous lengths of stay may apply under certain state laws, when applicable. In such cases, please refer to plan documents for a description of these richer guidelines.

Women's Health and Cancer Rights Act Notice

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

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

Any benefits payable will be subject to the same deductibles, coinsurance and other provisions applicable to other surgical and medical benefits provided under the plan. Please see your Summary of Benefits and Coverage (SBC) or other plan materials for your medical and surgical deductible and coinsurance information.

To request more information on WHCRA benefits, please contact Human Resources Department at 319-393-7811 or hresources@hacap.org.

Michelle's Law Notice

Health plans which extend coverage to full-time students age 26 or older are required to comply with Michelle's Law, an amendment to ERISA allowing students to take up to 12 months medical leave of absence *without causing a reduction in their health care coverage*.

This means that coverage for dependent children aged 26 or older cannot be immediately terminated due to loss of student status caused by a medically necessary leave of absence protected under Michelle's Law. Instead, any such termination of coverage will not occur before the date that is the earlier of:

- 12 months (one year) after the first day of the medically necessary leave of absence, or
- The date on which such coverage would otherwise terminate under the terms of the plan (see ERISA §714(b)).

A medically necessary leave of absence generally means a leave of absence from or other change in enrollment status in a postsecondary educational institution that begins while the child is suffering from a serious illness or injury; is medically necessary; and causes the child to lose student status for purposes of coverage under the terms of the plan or coverage. Certification by a treating physician stating that the dependent child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary may be requested in certain circumstances, however.

Please see plan materials for details pertaining to eligibility for full-time students aged 26 or older. Additional information about protections afforded under Michelle's Law can be found at https://www.law.cornell.edu/uscode/text/29/1185c.

Notice of Patient Protections and Selection of Providers

Designation of Primary Care Providers

If the health plan in which you are enrolled (or are enrolling) requires the designation of a primary care provider (or "PCP"), please note that you have the right to designate any primary care provider who participates in the plan's provider network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.

For information on how to select a primary care provider as well as a list of the participating primary care providers, contact the plan's insurer/TPA listed on your ID Card and other plan materials.

Direct Access to Obstetrics or Gynecological Specialists

If the health plan in which you are enrolled (or are enrolling) requires referrals to see specialists, you do not need prior authorization to obtain direct access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. Please note, however, that the health care professional may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals, if applicable.

For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the plan's insurer/TPA listed on your ID Card and other plan materials.

General Notice of COBRA Continuation Coverage Rights

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

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

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or

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

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

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

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

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights can be directed to Human Resources Department at 319-393-7811 or hresources@hacap.org. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans subject to ERISA, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa.

For more information about the Marketplace, visit www.healthcare.gov.

Keep your Plan informed of address changes

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

Termination of Coverage for Cause

Please be advised that our Plan reserves the right to terminate coverage for cause, when applicable and as permitted by the Plan's rules and/or administrative guidelines.

Presumption of COBRA and USERRA Concurrent Election Disclosure

Please note that any continuation rights under COBRA and the Uniformed Services Employment and Reemployment Rights Act (USERRA), when applicable, are similar but not identical. When both are available, the election for continuation coverage that you, the employee, make pursuant to COBRA will also be considered your election under USERRA for you and your covered dependents. Thus, USERRA will apply with respect to the COBRA continuation coverage elected by you and any COBRA continuation coverage elected by your covered dependents. Continuation coverage under both statutes will run concurrently (at the same time), so that, for example, when your (or your covered dependent's) first 18 months of concurrent COBRA and USERRA continuation coverage ends, you (or your covered dependent) will have up to an additional six months of continuation coverage under USERRA.

For periods of time in which you (or your covered dependents) have continuation coverage pursuant to both COBRA and USERRA, the law that provides the greater benefit will apply. The administrative policies and procedures described in our COBRA Election Notice (for example, the procedures for how to elect COBRA coverage and for paying premiums for COBRA coverage) also apply to USERRA coverage, unless compliance with the COBRA procedures is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

If you have continuation rights under both laws, instead of making the combined COBRA and USERRA election described above you may make an election under only COBRA or, alternatively, you may make an election under only USERRA. For information about how to make a USERRA-only or COBRA-only election please contact Human Resources Department at 319-393-7811 or hresources@hacap.org.

If you are Medicare Eligible, please keep this notice for your records!

NOTE: THE PRIMARY INSURED IS RESPONSIBLE FOR PROVIDING THIS NOTICE TO ALL MEDICARE ELIGIBLE FAMILY MEMBERS (or those about to become Medicare Eligible)!

Notice of Creditable Coverage for the 2027 Plan Year

We have determined that the prescription drug coverage provided under the Hawkeye Area Community Action Program, Inc. Welfare Benefit Plan is expected to pay out, on average, the same or more than what the standard Medicare prescription drug coverage will pay. This is known as "creditable coverage" as defined by the Medicare Modernization Act (MMA).

Why This is Important

When someone first becomes eligible to enroll in a government-sponsored Medicare "Part D" prescription drug plan, enrollment is considered timely if completed by the end of his or her "Initial Enrollment Period" which ends 3 months after the month in which he or she turned age 65.

Unfortunately, if you choose not to enroll in Medicare Part D during your Initial Enrollment Period, *when you finally do enroll* **you may be subject to a late enrollment penalty** added to your monthly Medicare Part D premium. Specifically, the extra cost, if any, increases *based on the number of full, uncovered months* during which you went without either Medicare Part D or else without "creditable" prescription drug coverage from another source (such as ours).

It is important for those eligible for both Medicare and our group health plan to look ahead and weigh the costs and benefits of the various options on a regular, if not annual, basis. Based on individual facts and circumstances some choose to elect Medicare only, some choose to elect coverage under the group health plan only, while some choose to enroll in both coverages. When both are elected, please note that benefits coordinate according to the Medicare Secondary Payer Rules. That is, one plan or the other would *reduce payment* in order to prevent you from being reimbursed the full amount from both sources. Your age, the reason for your Medicare eligibility and other factors determine which plan is primary (pays first, generally without reductions) versus secondary (pays second, generally with reductions).

Eligible individuals can enroll in a Medicare Part D prescription drug plan during Medicare's "Annual Coordinated Election Period" (a.k.a. "Open Enrollment Period") running from Oct. 15 through Dec. 7 of each year, as well during what is known as a "Medicare Special Enrollment Period" (which is triggered by certain qualifying events, including the loss of creditable group prescription drug coverage). **Those who miss these opportunities are generally unable to enroll in a Medicare Part D plan until another enrollment period becomes available**. Finally, please be cautioned that even if you elect our coverage, you could be subject to a payment of higher Part D premiums if you subsequently experience a break in coverage of 63 continuous days or longer before enrolling in the Medicare Part D plan. Carefully coordinating your transition between plans is therefore essential.

If you are unsure as to whether or when you will become eligible for Medicare, or if you have questions about how to get help to pay for it, please call the Social Security Administration at (800) 772-1213 or visit socialsecurity.gov. Specific questions about our prescription drug coverage should be directed to the customer service number on your ID card, if enrolled, or to Human Resources Department at 319-393-7811 or hresources@hacap.org.

Wellmark Alliance Select $2,500 PPO HDHP

NOTE: THE PRIMARY INSURED IS RESPONSIBLE FOR PROVIDING THIS NOTICE TO ALL MEDICARE ELIGIBLE FAMILY MEMBERS (or those about to become Medicare Eligible)!

Notice of Non-Creditable Coverage for the 2027 Plan Year

We have determined that the prescription drug coverage provided under the Hawkeye Area Community Action Program, Inc. Welfare Benefit Plan is expected to pay out, on average, LESS THAN what the standard Medicare prescription drug coverage will pay. This is known as "non-creditable coverage" as defined by the Medicare Modernization Act (MMA).

Why This is Important

When someone first becomes eligible to enroll in a government-sponsored Medicare "Part D" prescription drug plan, enrollment is considered timely if completed by the end of his or her "Initial Enrollment Period" which ends 3 months after the month in which he or she turned age 65.

Unfortunately, if you choose not to enroll in Medicare Part D during your Initial Enrollment Period, when you finally do enroll you may be subject to a late enrollment penalty added to your monthly Medicare Part D premium. Specifically, the extra cost, if any, increases based on the number of full, uncovered months during which you went without either Medicare Part D or else without "creditable" prescription drug coverage (obtained through another source).

It is important for those eligible for both Medicare and our group health plan to look ahead and weigh the costs and benefits of the various options on a regular, if not annual, basis. Based on individual facts and circumstances some choose to elect Medicare only, some choose to elect coverage under the group health plan only, while some choose to enroll in both coverages. When both are elected, please note that benefits coordinate according to the Medicare Secondary Payer Rules. That is, one plan or the other would reduce payment in order to prevent you from being reimbursed the full amount from both sources. Your age, the reason for your Medicare eligibility and other factors determine which plan is primary (pays first, generally without reductions) versus secondary (pays second, generally with reductions).

Eligible individuals can enroll in a Medicare Part D prescription drug plan during Medicare's "Annual Coordinated Election Period" (a.k.a. "Open Enrollment Period") running from Oct. 15 through Dec. 7 of each year, as well during what is known as a "Medicare Special Enrollment Period" (which is triggered by certain qualifying events, including the loss of creditable group prescription drug coverage). Those who miss these opportunities are generally unable to enroll in a Medicare Part D plan until another enrollment period becomes available. Finally, please be cautioned that even if you elect our coverage, you could be subject to a payment of higher Part D premiums if you subsequently experience a break in coverage of 63 continuous days or longer before enrolling in the Medicare Part D plan. Carefully coordinating your transition between plans is therefore essential.

If you are unsure as to whether or when you will become eligible for Medicare, or if you have questions about how to get help to pay for it, please call the Social Security Administration at (800) 772-1213 or visit socialsecurity.gov. Specific questions about our prescription drug coverage should be directed to the customer service number on your ID card, if enrolled, or to Human Resources Department at 319-393-7811 or hresources@hacap.org.

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



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 from Medicaid in paying for your employer health plan premiums. The following list of states is current as of Jul. 31, 2025. 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
Website: https://www.in.gov/medicaid/ or http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864, Member Services Phone: 1-800-457-4584

IOWA – Medicaid & CHIP (Hawki)
Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid Phone: 1-800-338-8366
Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
HIPP Phone: 1-888-346-9562

KANSAS | Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPAA 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://kynect.ky.gov
Phone: 1-877-524-4718

KENTUCKY | Medicaid (continued)
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 & 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/healthcare-coverage/
Phone: 1-800-657-3672

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
Medicaid Website:
https://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE | Medicaid
Website:
https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY | Medicaid & CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/ index.html
CHIP Phone: 1-800-701-0710 (TTY 711)

NEW YORK | Medicaid
Website:
https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA | Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA | Medicaid
Website:
https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA | Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON | Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA | Medicaid & CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website:
https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND | Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA | Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA | Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS | Medicaid
Website:
https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH | Medicaid & CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website:
https://medicaid.utah.gov/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website:
https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/

UTAH | Medicaid & CHIP (continued)
CHIP Website:
http://health.utah.gov/chip

VERMONT | Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA | Medicaid & CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON | Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA | Medicaid and CHIP
Website: https://dhhr.wv.gov.bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN | Medicaid & CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING | Medicaid
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 Jul. 31, 2025, 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

Glossary of Terms

This glossary has many commonly used terms, but it isn't a full list. These are not contract terms. Those can be found in your insurance policy or certificate.

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Appeal: A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing: When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you.

Co-insurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. (Jane pays 20%, her plan pays 80%.)

Complications of Pregnancy: Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency cesarean section aren't complications of pregnancy.

Co-payment: A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible: The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services. (Jane pays 100%, her plan pays 0%.)

Durable Medical Equipment (DME): Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition: An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm. Emergency Medical Transportation Ambulance services for an emergency medical condition.

Emergency Room Care: Emergency services received in an emergency room.

Emergency Services: Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services: Health care services that your health insurance or plan doesn't pay for or cover.

Grievance: A complaint that you communicate to your health insurer or plan.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance: A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care: Health care services a person receives at home.

Hospice Services: Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care: Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance: The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Co-payment: A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

Medically Necessary: Health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine.

Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider: A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non- preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Out-of-Network Co-insurance: The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-Network Co-payment: A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network copayments.

Out-of-Pocket Limit: The most you pay during policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit. (Jane pays 0%, her plan pays 100%.)

Physician Services: Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan: A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization: A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider: A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium: The amount that must be paid for your health insurance or plan. You and or your employer usually pay it yearly.

Prescription Drug Coverage: Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs: Drugs and medications that by law require a prescription.

Primary Care Physician: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery: Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services: Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care: Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist: A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.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