



BENEFITS GUIDE

2026

Contact Information



Coverage	Carrier	Phone	Website
Medical & Pharmacy	PHP TPA Services	260-436-9495 or 800-551-7334	tpaservices.vbagateway.com
Provider Network - Northeast Indiana	PHP Freedom	260-436-9495 or 800-551-7334	tpaservices.vbagateway.com
Provider Network - resides outside PHP Freedom Network	First Health Network	800-226-5116	www.myfirsthealth.com
Prescription Drug & Mail Order	Prime Therapeutics	800-424-0472	www.primetherapeutics.com
Prescription Drug Program	RX Valet	706-450-6536	www.papsc@MyRxValet.com
LabCard Program	LabCorp	PHP TPA: 260-436-9495 or customerservice@ phpni.com	www.labcorp.com
Imaging Facility	Direct Imaging	260-212-1901	www.directcarellc.net
24/7 Unlimited Doctor Access	First Stop Health	888-691-7867	firststophealth.com
Dental	PHP TPA Services	260-436-9495 or 800-551-7334	tpaservices.vbagateway.com
Voluntary Vision	United Healthcare	800-638-3120 or 800-839-3242 Provider Locator	www.myuhcvision.com
Health Reimbursement Account (HRA)	PHP TPA Services	260-436-9495 or 800-551-7334	tpaservices.vbagateway.com
Health Savings Account (HSA) - for HDHP participants	UMB	866-520-4472	HSA.UMB.com
Flexible Spending Accounts (FSA)	HealthEquity	866-346-5800	my.healthequity.com

Contact Information



Coverage	Carrier	Phone	Website
Life/AD&D	Symetra	800-796-3872	www.symetra.com
Voluntary Life/AD&D	Symetra		
Short Term Disability	Symetra		
Long Term Disability	Symetra		
Hospital Indemnity	UNUM	800-423-2765	www.unum.com
Accident	UNUM		
Critical Illness	UNUM		
Whole Life Insurance	Atlantic American	866-458-7502	www.aaemployeebenefits.com
Employee Assistance Program (EAP)	Parkview	260-266-8060 or 800-721-8809	www.parkviewtotalhealth.com
457 Plan	Lincoln Financial Group	Lincoln Financial Advisors 260-637-0800	www.LincolnFinancial.com Log in: Employer Retirement Plans
457 Plan	Nationwide	260-385-6336 Patrick Burkhart	Email: burkhps@nationwide.com
Indiana Public Employee Retirement System	INPRS	844-GO-INPRS	www.inprs.in.gov

Introduction



We understand the important role that benefits play in the lives of you and your family. As a new hire and then annually during open enrollment, you have an opportunity to make changes to your benefits package to ensure you and your family have the right coverage.

This benefits guide can help you familiarize yourself with your benefit options. It also provides useful tips, tools, and resources to help you consider your options and make wise decisions.

As you prepare to enroll:

- Consider your benefit coverage needs for the upcoming year. For example, is your family financially protected if you can't work due to an accident or illness?
- Consider other available coverage.
- Gather information you'll need. If you are covering dependents, you will need their dates of birth and Social Security numbers.

Getting the most value from your benefits depends on how well you understand your plans and how you choose to use them. Be sure to read this entire guide for important information about your benefit options.

Enrollment Support / HR

HR & Benefits Manager

Laura Helmkamp
260-427-2634
Laura.Helmkamp@cityoffortwayne.org

Benefits & Wellness Coordinator

Katie Adams
260-427-6910
Katie.Adams@cityoffortwayne.org

Benefits Support

Partner / Benefits Consultant

John E. Ryan
260-413-6288 / 260-557-1344
john@dehayes.com

Benefits Consultant

Corey Ryan
260-969-8996
corey@dehayes.com

Customer Service Agent

Sandy Eifert
260-557-1977
sandy@dehayes.com

Eligibility/Claims Specialist

Wendy Gatwood
260-440-2951
wendy@dehayes.com

Enrolling in Your Benefits



Log into the portal
<https://fortwayne.benefitsinfo.com>



Click on Start Enrollment



Elect the benefits you want and decline the coverages you don't



Review and submit your elections



Employee Costs



\$1,200 Deductible Plan (with Dental)

Traditional Plan

- \$30 OV Co-pay, \$15/\$40/\$60 Rx Co-Pay
- 80/20 Co-insurance, Single Max OOP - \$3,700

MONTHLY RATES

Employee Only	\$76.00
Employee + Spouse Secondary*	\$107.00
Employee + 1 Primary (Spouse or Child)	\$141.00
Employee + Family without Spouse	\$152.00
Employee + Family Spouse Secondary*	\$165.00
Employee + Family Spouse Primary	\$197.00

Dental Only

- \$50 Deductible, \$1,200 Annual Maximum
- 100% Preventive
- 90% Basic
- 60% Major

MONTHLY RATES

Employee Only	\$13.00
Employee + Spouse Secondary*	\$22.00
Employee + 1 Primary (Spouse or Child)	\$33.00

\$3,400 Deductible Plan (with Dental)

High Deductible Health Plan (HDHP)

- 100% after deductible with exception of \$150 ER co-pay and \$40/\$60 copay on name brand Rx (after deductible has been met)

MONTHLY RATES

Employee Only	\$39.00
Employee + Spouse Secondary*	\$54.00
Employee + 1 Primary (Spouse or Child)	\$72.00
Employee + Family without Spouse	\$77.00
Employee + Family Spouse Secondary*	\$84.00
Employee + Family Spouse Primary	\$99.00

* "Spouse Secondary" means your spouse is covered through their employer and the City's plan will be secondary. If your spouse is not covered by another plan, the City's plan will be primary.



Voluntary Vision Plan

Employee Only	\$6.76
Employee + Spouse	\$13.19
Employee + Child(ren)	\$13.87
Employee + Family	\$21.30

PREMIUMS ARE DEDUCTED ON A BI-WEEKLY BASIS

To calculate premium cost per paycheck: Monthly Rate x 12 (months) ÷ 26 (pay periods)

Basic Life/AD&D, Short Term Disability, Long Term Disability and Employee Assistance Program (EAP) is provided at no cost to you by City of Fort Wayne (STD/LTD for non-public safety employees only)

Employee Costs



Supplemental Life Insurance Rates per Payroll Deduction (24)

EMPLOYEE	<34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+	AD&D
\$10,000	\$0.35	\$0.55	\$0.85	\$1.40	\$2.50	\$4.10	\$5.45	\$8.50	\$15.00	\$24.70	\$0.15
\$20,000	\$0.70	\$1.10	\$1.70	\$2.80	\$5.00	\$8.20	\$10.90	\$17.00	\$30.00	\$49.40	\$0.30
\$30,000	\$1.05	\$1.65	\$2.55	\$4.20	\$7.50	\$12.30	\$16.35	\$25.50	\$45.00	\$74.10	\$0.45
\$40,000	\$1.40	\$2.20	\$3.40	\$5.60	\$10.00	\$16.40	\$21.80	\$34.00	\$60.00	\$98.80	\$0.60
\$50,000	\$1.75	\$2.75	\$4.25	\$7.00	\$12.50	\$20.50	\$27.25	\$42.50	\$75.00	\$123.50	\$0.75
\$60,000	\$2.10	\$3.30	\$5.10	\$8.40	\$15.00	\$24.60	\$32.70	\$51.00	\$90.00	\$148.20	\$0.90
\$70,000	\$2.45	\$3.85	\$5.95	\$9.80	\$17.50	\$28.70	\$38.15	\$59.50	\$105.00	\$172.90	\$1.05
\$80,000	\$2.80	\$4.40	\$6.80	\$11.20	\$20.00	\$32.80	\$43.60	\$68.00	\$120.00	\$197.60	\$1.20
\$90,000	\$3.15	\$4.95	\$7.65	\$12.60	\$22.50	\$36.90	\$49.05	\$76.50	\$135.00	\$222.30	\$1.35
\$100,000	\$3.50	\$5.50	\$8.50	\$14.00	\$25.00	\$41.00	\$54.50	\$85.00	\$150.00	\$247.00	\$1.50
\$200,000	\$7.00	\$11.00	\$17.00	\$28.00	\$50.00	\$82.00	\$109.00	\$170.00	\$300.00	\$494.00	\$3.00
\$300,000	\$10.50	\$16.50	\$25.50	\$42.00	\$75.00	\$123.00	\$163.50	\$255.00	\$450.00	\$741.00	\$4.50
\$400,000	\$14.00	\$22.00	\$34.00	\$56.00	\$100.00	\$164.00	\$218.00	\$340.00	\$600.00	\$988.00	\$6.00
\$500,000	\$17.50	\$27.50	\$42.50	\$70.00	\$125.00	\$205.00	\$272.50	\$425.00	\$750.00	\$1,235.00	\$7.50
*SPOUSE	<34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+	AD&D
\$5,000	\$0.18	\$0.28	\$0.43	\$0.70	\$1.25	\$2.05	\$2.73	\$4.25	\$7.50	\$12.35	\$0.08
\$10,000	\$0.35	\$0.55	\$0.85	\$1.40	\$2.50	\$4.10	\$5.45	\$8.50	\$15.00	\$24.70	\$0.15
\$15,000	\$0.53	\$0.83	\$1.28	\$2.10	\$3.75	\$6.15	\$8.18	\$12.75	\$22.50	\$37.05	\$0.23
\$20,000	\$0.70	\$1.10	\$1.70	\$2.80	\$5.00	\$8.20	\$10.90	\$17.00	\$30.00	\$49.40	\$0.30
\$25,000	\$0.88	\$1.38	\$2.13	\$3.50	\$6.25	\$10.25	\$13.63	\$21.25	\$37.50	\$61.75	\$0.38
\$30,000	\$1.05	\$1.65	\$2.55	\$4.20	\$7.50	\$12.30	\$16.35	\$25.50	\$45.00	\$74.10	\$0.45
\$35,000	\$1.23	\$1.93	\$2.98	\$4.90	\$8.75	\$14.35	\$19.08	\$29.75	\$52.50	\$86.45	\$0.53
\$40,000	\$1.40	\$2.20	\$3.40	\$5.60	\$10.00	\$16.40	\$21.80	\$34.00	\$60.00	\$98.80	\$0.60
\$45,000	\$1.58	\$2.48	\$3.83	\$6.30	\$11.25	\$18.45	\$24.53	\$38.25	\$67.50	\$111.15	\$0.68
\$50,000	\$1.75	\$2.75	\$4.25	\$7.00	\$12.50	\$20.50	\$27.25	\$42.50	\$75.00	\$123.50	\$0.75
\$100,000	\$3.50	\$5.50	\$8.50	\$14.00	\$25.00	\$41.00	\$54.50	\$85.00	\$150.00	\$247.00	\$1.50
	CH Life	CH AD&D	CH Life	CH AD&D	CH Life	CH AD&D	CH Life	CH AD&D	CH Life	CH AD&D	
CHILD(REN)	\$2,000	\$2,000	\$4,000	\$4,000	\$6,000	\$6,000	\$8,000	\$8,000	\$10,000	\$10,000	
	\$0.07	\$0.03	\$0.14	\$0.06	\$0.21	\$0.09	\$0.28	\$0.12	\$0.35	\$0.15	

*Spouse's rate is based on spouse's age.

Eligibility



You are eligible to participate in the benefits described in this summary if you meet the definition of an “eligible employee or retiree” and have satisfied the waiting period.

Who's an Eligible Dependent?

- Your legal spouse
- Your children up to age 26

When Can You Enroll?

- As a new hire, at your initial eligibility date.
- During the annual open enrollment period, effective January 1st of each year.
- Within 30 days of a qualified family-status change.

When Does Coverage End?

Coverage will end on the last day of the month following your termination date.

When Does Coverage Begin?

Coverage will begin on the 31st day of employment

Spousal Coordination of Benefits

A working spouse eligible for medical expense insurance under a plan sponsored by the spouse's employer is required to take that coverage and then can be covered under the City of Fort Wayne's plan as secondary if elected. See Summary Plan Description for details.

Your spouse's failure to enroll under the other employer plan will not constitute eligibility under this Plan.

Making Changes

Generally, you may only make or change your existing benefit elections as a new hire or during the annual open enrollment period. However, you may change your benefit elections during the year if you experience an event such as:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Loss or gain of other coverage by the employee or dependent
- Eligibility for Medicare or Medicaid

Open Enrollment

The Plan includes an annual Open Enrollment Period during which time the employee may change benefit elections or enroll himself and/or dependents in the Plan if he did not do so when first eligible or does not qualify for a Special Enrollment Period. Coverage elections made during an Open Enrollment Period are effective January 1st.



MEDICAL



Medical Insurance



City of Fort Wayne offers eligible employees and their dependents a comprehensive PPO (Preferred Provider Organization) health insurance plan administered by PHP TPA Services.

PHP TPA Services Member Portal

tpaservices.vbagateway.com



TRADITIONAL PLAN - Grandfathered	PPO Providers	Non-PPO Providers
Deductible	\$1,200 Individual / \$3,600 Family	\$4,200 Individual / \$12,600 Family
Coinsurance	80% / 20%	50% / 50%
Out-of-Pocket Maximum (per cal yr) Include deductible & coinsurance	\$3,700 Individual / \$8,600 Family	\$18,200 Individual / \$40,600 Family
Physician Office Visit (Visit only) All other services subject to ded & coins.	\$30 copay	50% after deductible
Preventive Services Office visits/Routine exam, immunizations, prostate exams w/PSA's, well woman exam w/pap, mammogram	\$30 copay up to \$2,000 benefit, then deductible, then 20% Colonoscopy - 100%, no deductible	50% after deductible Colonoscopy - not covered
Emergency Room	80% after deductible	80% after deductible
Urgent Care Visit (Visit only) All other services subject to ded & coins.	\$35 copay	\$35 copay
Laboratory Services If LabCorp used: 100%, not subject to ded	80% after deductible	50% after deductible
Prescription Drugs - Retail /Mail Order 34 day supply / 90 day supply (Walgreens is excluded) <i>*Member pays difference between generic and brand plus \$15 when brand prescribed & generic available, unless physicians mandates "dispense as written"</i>	Generic - \$15 copay / \$30 copay *Preferred Brand - \$40 copay / \$80 copay *Non-Preferred - \$60 copay / \$120 copay Specialty (34 days) - 100% after ded (Must use Specialty Pharmacy)	Not covered

- The out-of-pocket limit does NOT include copays, cost containment penalties, charges in excess of allowable and any ineligible charge
- Benefits apply to network retail pharmacies, no coverage at Walgreens
- Balance billing protection when you use an in-network provider
- In-patient hospital admissions and many out-patient procedures require mandatory notification to Valenz: 877-608-2200



Medical Insurance



City of Fort Wayne offers eligible employees and their dependents a comprehensive PPO (Preferred Provider Organization) health insurance plan administered by PHP TPA Services.

PHP TPA Services Member Portal

tpaservices.vbagateway.com



HDHP - Grandfathered	PPO Providers	Non-PPO Providers
Deductible	\$3,400 Individual / \$6,800 Family	\$7,000 Individual / \$14,000 Family
Coinsurance	100% / 0%	50% / 50%
Out-of-Pocket Maximum (per cal yr) Include deductible & coinsurance	\$3,400 Individual / \$6,800 Family	\$21,00 Individual / \$42,000 Family
Physician Office Visit (Visit only) All other services subject to ded & coins.	100% after deductible	50% after deductible
Preventive Services Office visits/Routine exam, immunizations, prostate exams w/PSA's, well woman exam w/pap, mammogram	100% up to \$2,000 benefit, then 100% after deductible Colonoscopy - 100%, no deductible	50% after deductible Colonoscopy - not covered
Emergency Room	Deductible, then \$150 copay, then 100%	Deductible, then \$150 copay, then 100%
Urgent Care Visit (Visit only) All other services subject to ded & coins.	100% after deductible	50% after deductible; plan pays network level if medical emergency
Laboratory Services If LabCorp used: 100%, after to ded	100% after deductible	50% after deductible
Prescription Drugs - Retail /Mail Order 34 day supply / 90 day supply (Walgreens is excluded) <i>*Member pays difference between generic and brand plus \$15 when brand prescribed & generic available, unless physicians mandates "dispense as written"</i>	Must meet deductible before copays apply Generic - \$0 copay / \$0 copay *Preferred Brand - \$40 copay / \$80 copay *Non-Preferred - \$60 copay / \$120 copay Specialty (34 days) - 100% after ded	Not covered

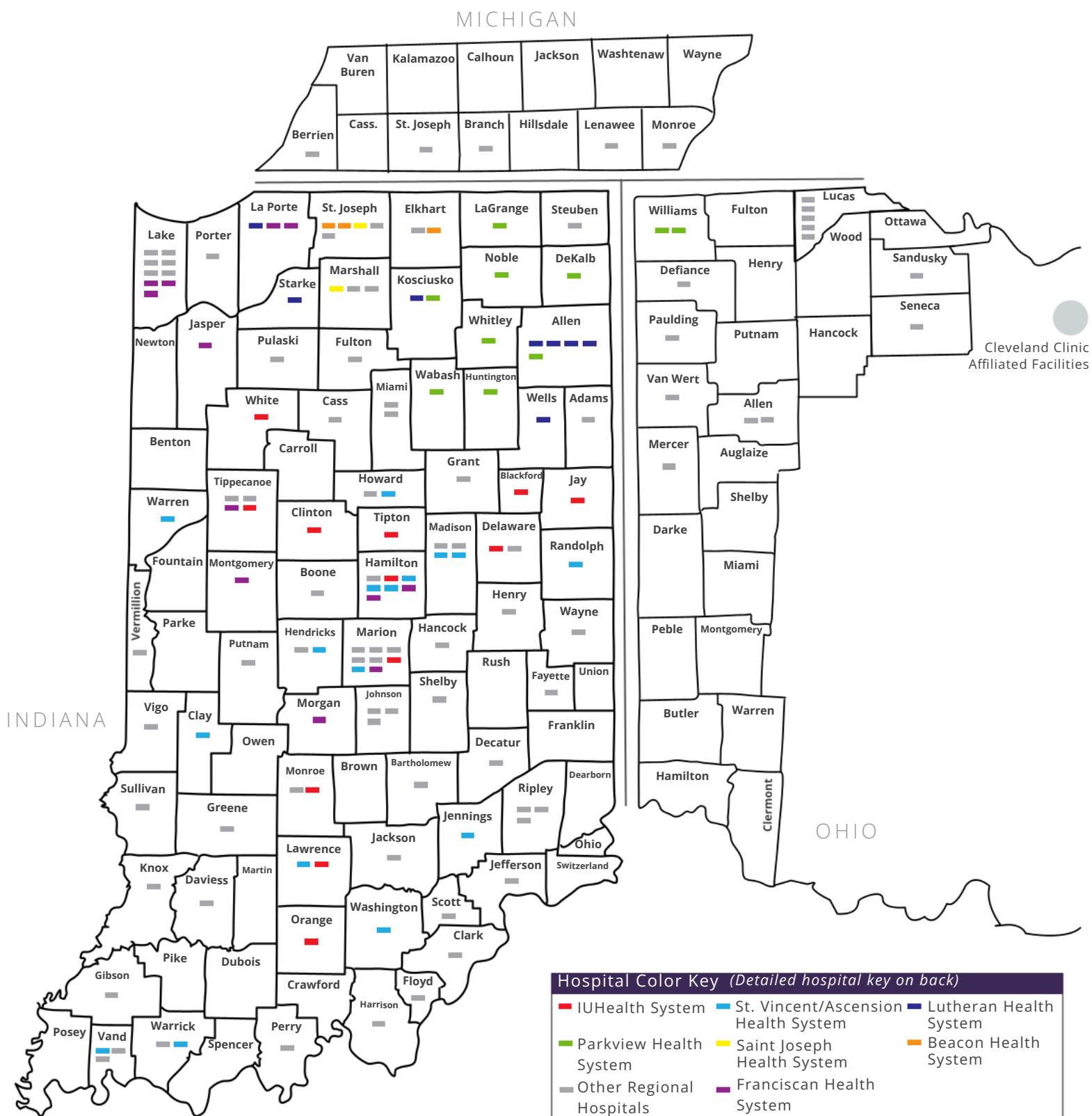
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- In-patient hospital admissions and many out-patient procedures require mandatory notification to Valenz: 877-608-2200



INDIANA, MICHIGAN AND OHIO

PHP Network Hospitals

FREEDOM
network



National network coverage for employees residing outside of the PHP service area is available through the First Health® Network and the Cofinity® Network.

Adams County	Henry County	St. Joseph Regional Medical Center
Adams County Memorial Hospital	Henry County Memorial Hospital	Miami County
Allen County	Howard County	Community Howard Regional Health
Dupont Hospital	Community Howard Regional Health	Dukes Memorial Hospital
Lutheran Downtown Hospital	St. Vincent Kokomo Hospital	Monroe County
Lutheran Hospital	Huntington County	Bloomington Meadows Hospital
Parkview Regional Medical Center	Parkview Huntington Hospital	IU Health Bloomington Hospital
Rehabilitation Hospital	Jackson County	Montgomery County
Bartholomew County	Jackson County Memorial Hospital	Franciscan Health Crawfordsville
Columbus Regional Hospital	Jasper County	Morgan County
Blackford County	Franciscan Health Rensselaer	Franciscan Health Mooresville
IU Health Blackford Hospital	Jay County	Noble County
Boone County	IU Health Jay Hospital	Parkview Noble Hospital
Witham Memorial Hospital	Jefferson County	Orange County
Cass County	King's Daughters' Hospital	IU Paoli Hospital
Logansport Memorial Hospital	Jennings County	Perry County
Clark County	St. Vincent Jennings Hospital	Perry County Memorial Hospital
Clark Memorial Hospital	Johnson County	Porter County
Clay County	Community Health Network	Porter Regional Hospital
St. Vincent Clay Hospital	Johnson Memorial Hospital	Pulaski County
Clinton County	Rehabilitation Hospital	Pulaski Memorial Hospital
IU Health Frankfort Hospital	Knox County	Putnam County
Daviess County	Good Samaritan Hospital	Putnam County Hospital
Daviess Community Hospital	Kosciusko County	Randolph County
Decatur County	Kosciusko Community Hospital	St. Vincent Randolph Hospital
Decatur County Memorial Hospital	Parkview Warsaw Hospital	Ripley County
DeKalb County	Lake County	Magaret Mary Community Hospital
Parkview DeKalb Hospital	Community Hospital Munster	Progressive Cancer Care Center
Delaware County	Franciscan Health Crown Point	Regency Hospital of Porter County
Central Indiana AMG Specialty Hospital	Franciscan Health Dyer	Scott County
IU Health Ball Memorial Hospital	Franciscan Health Munster	Scott Memorial Hospital
Elkhart County	Kindred Hospital Indiana	Shelby County
Elkhart General Hospital	Methodist Hospital	Major Hospital
Goshen General Hospital	Regency Hospital of Northwest Indiana	St. Joseph County
Fayette County	St. Catherine Hospital	Beacon Granger Hospital
Reid Hospital and Healthcare Services	St. Mary's Medical Center	Memorial Hospital of South Bend
Floyd County	LaGrange County	Rehabilitation Hospital of Northern Indiana
Physicians Medical Center	Parkview LaGrange Hospital	Rivercrest Specialty Hospital
Fulton County	La Porte County	St. Joseph Regional Medical Center
Woodlawn Hospital	Franciscan Health Michigan City	Starke County
Gibson County	Franciscan Health Michigan City - La Porte	Northwest Starke Hospital
Gibson General Hospital	Northwest Health-La Porte	Steuben County
Grant County	Lawrence County	Cameron Memorial Community Hospital
Marion General Hospital	IU Health Bedford Hospital	Sullivan County
Greene County	St. Vincent Dunn Hospital	Sullivan County Community Hospital
Greene County General Hospital	Madison County	Tippecanoe County
Hamilton County	Community Hospital of Anderson &	Franciscan Health Lafayette
Franciscan Orthopedic Hospital Carmel	Madison County	IU Health Arnett Hospital
Franciscan Health Carmel	St. Vincent Anderson Regional Hospital	Lafayette Home Hospital
IU Health North Hospital	St. Vincent Mercy Hospital	River Bend Hospital
Riverview Hospital	Marion County	Tipton County
St. Vincent Carmel Hospital	Community Hospital	IU Tipton Hospital
St. Vincent Fishers Hospital	Franciscan Health Indianapolis	Vanderburgh County
St. Vincent Hospital & Health Centers	Kindred Hospital Indiana	Deaconess Hospital
Hancock County	IU Health Hospital	Select Specialty Hospital Evansville
Hancock Regional Hospital	Orthoindy Hospital	St. Vincent Evansville Hospital
Harrison County	Riley Hospital for Children	Vermillion County
Harrison County Hospital	Rehabilitation Hospital of Indiana	Union Community Hospital Clinton
Hendricks County	St. Vincent Hospital & Health Centers	Vigo County
Hendricks Regional Health	Marshall County	Union Community Hospital
St. Vincent Hospital & Health Centers	Community Hospital of Bremen	Wabash County
	Doctor's Hospital	Parkview Wabash Hospital

PHP Network Hospitals Key

Washington County

- St. Vincent Salem Hospital
Warrick County

- Deaconess Gateway Hospital

- St. Vincent Warrick Hospital
Warren County

- St. Vincent Williamsport Hospital
Wayne County

- Reid Hospital and Healthcare Services
Wells County

- Bluffton Regional Medical Center
White County

- IU White Memorial Hospital
Whitley County

- Parkview Whitley Hospital

MICHIGAN

Berrien County

- Corewell Health Lakeland Hospital
Branch County

- ProMedica Coldwater Regional Hospital
Lenawee County

- ProMedica Charles and Virginia Hickman Hospital
Monroe County

- ProMedica Monroe Regional Hospital
St. Joseph County

- Sturgis Hospital

OHIO

Allen County

- Institute for Orthopaedic Surgery

- Lima Memorial Hospital
Cuyahoga County

- Cleveland Clinic
Defiance County

- ProMedica Defiance Regional Hospital
Lake County

- Cleveland Clinic
Lucas County

- ProMedica Bay Park Hospital

- ProMedica Flower Hospital

- ProMedica Russell J. Ebeid Children's Hospital

- ProMedica Toledo Hospital

- ProMedica Wildwood Orthopaedic & Spine Hospital
Mercer County

- Mercer County Hospital
Paulding County

- Paulding County Hospital
Sandusky County

- ProMedica Memorial Hospital
Seneca County

- ProMedica Fostoria Community Hospital
Van Wert County

- Van Wert County Hospital
Williams County

- Parkview Byran Hospital

- Parkview Montpelier Hospital

Questions? Contact PHP Customer Service

800-982-6257 or 260-432-6690

custsvc@phpni.com

Learn more at phpni.com

2-6-2025



24/7 Online Tools and Resources

Set-up your new member portal at tpaservices.vbagateway.com! Take advantage of valuable tools and resources that are available to you with your PHP TPA health plan, such as:



Eligibility and claims details



Provider Finder



Virtual ID cards



Secure messaging and online chat



Cost estimator

Save money with the Cost Estimator by comparing cost estimates for common healthcare services among providers in your network. Use this tool to display total costs, out-of-pocket amounts, and more

Setting up your member portal is easy!

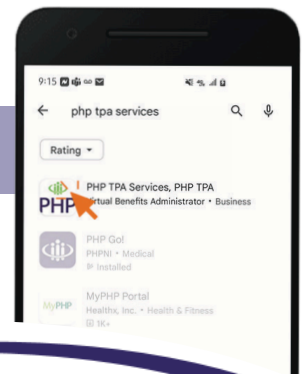
- 1 Visit tpaservices.vbagateway.com.
- 2 Select '**Click here to register and/or enroll.**'
- 3 Click '**Member**' from the drop-down box and enter the required information.

Username *	Register & Enroll Click here to register and/or enroll.
Password *	Supported Browsers Current and prior major release of and on a rolling basis. We recommend .
LOG IN	
I forgot my username or password	

Access your portal on the go with the PHP TPA Services Mobile App

Search for PHP TPA Services from the Apple App Store or Google Play. Once downloaded, login using your member portal credentials.

Search for PHP TPA Services

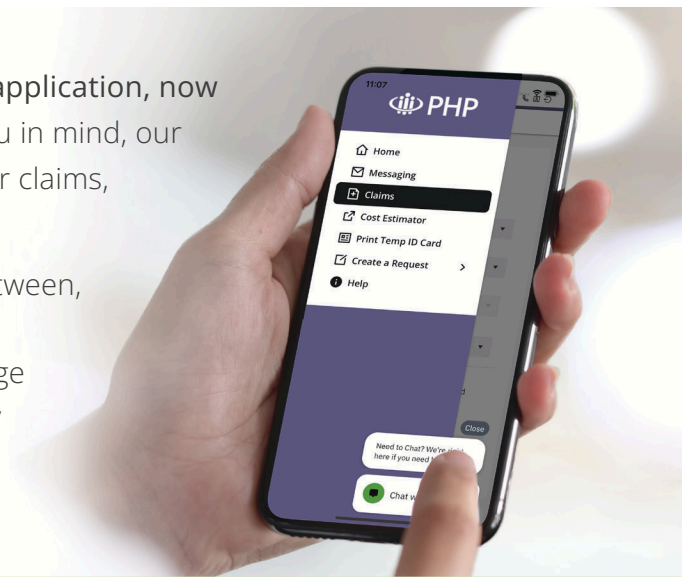


New look, same great benefits!

The NEW PHP TPA Services Member Mobile App

We're thrilled to announce the launch of our newest mobile application, now available for download on iOS and Android! Designed with you in mind, our app transforms the way you view coverage information, monitor claims, access documents, and interact with your plan.

Whether you're a busy professional, a student, or anyone in between, our application helps you streamline portal activities to a quick access mobile friendly application. It allows you to quickly engage with your coverage plan and information. Our goal is to simplify your life and keep you organized, motivated, and connected.

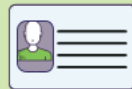


Upgraded Features Include:



Upgraded Architecture

Overall improved app performance with continued effort to expand functionality.



Easy Access

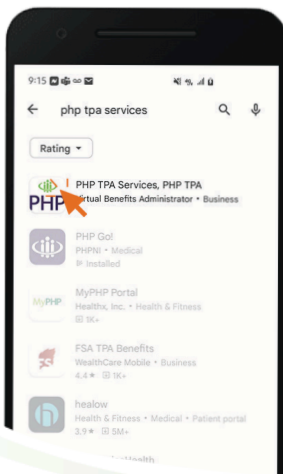
Quickly access your ID Cards, claims, and additional coverage information.



Better Design

User-friendly interface allows you to navigate effortlessly with our intuitive design.

Download the PHP TPA Services app today!



To get started, search for **PHP TPA Services** from the **Apple App Store** or **Google Play** and unlock a new way to engage with your coverage. Once downloaded, login using your member portal credentials.

If you have previously downloaded the PHP TPA Services Mobile App, all new and improved features will automatically appear once an app update is performed!



Search for PHP TPA Services.



Powered by:

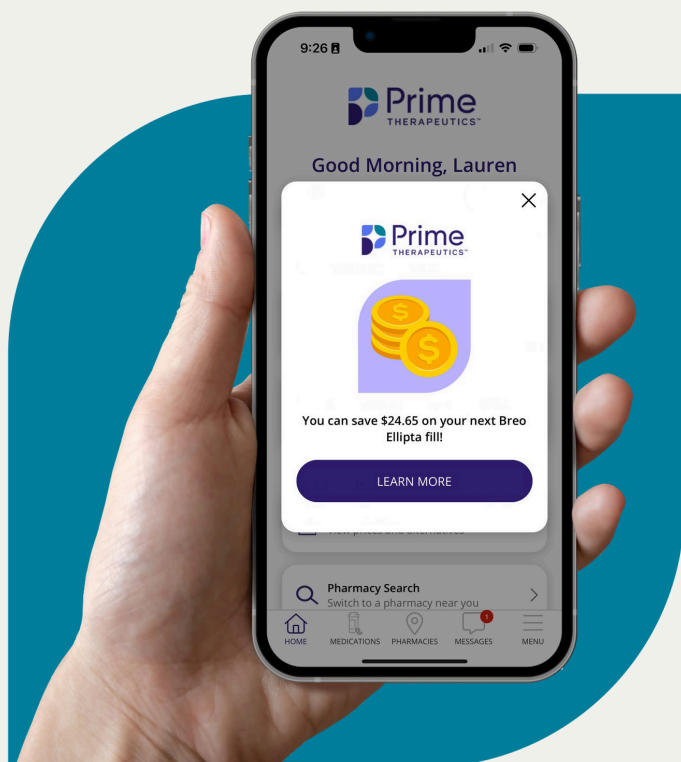


10-17-2024

1700 Magnavox Way, Suite 201 | Fort Wayne, IN 46804
Phone: 260-436-9495 | Toll Free: 800-551-7334
customerservice@phpni.com



INTRODUCING PrimeCentral™



Your one-stop app to
manage your
medications

WHEN TO USE PRIMECENTRAL:



To Find Savings

Get alerted of cost-saving opportunities and take action with a single tap.



With Your Doctor

Search for meds and choose the best option at the point of prescribing.



Before the Pharmacy

Check pricing and verify coverage details to avoid surprises at the pharmacy counter.



To Stay Informed

Access your Rx benefits card and turn on notifications to stay up-to-date.

Scan to Download!



PrimeCentral replaces the previous app and requires a new login. Information in the app is personalized to each member. Savings alert above is for illustrative purposes only.



RX VALET Cost Containment Program

Fact:

Prescription drugs costs have increased in the US by 35% over the past 5 years. Biologics (drugs you see on TV) cost from \$500 to over \$30,000 per month. Although these medications are effective, they are expensive! Unfortunately, this effects Health Insurance premiums that we all pay.

Solution:

RX VALET has created a systematic approach to managing high-cost prescription medications through all of the various cost saving programs available in the US and abroad.

How it works:

RX VALET gets involved on all high-cost medications? Our integrated technology allows us to identify all of the potential savings programs available. Our highly trained team will then engage with employees to determine what programs we can apply to each drug. In some cases, multiple programs may be utilized. RX VALET talks with the employee and manages the process. In most cases the savings options will include waiving their copay!

What is required from employees:

Communication is the key to our success. If RX VALET calls, emails or sends a text, it is in the best interest of the employee to respond. Our team is here to help them and your company save money. We may also ask them to fill out a few forms, request income status/dependents, and supply some documentation, but our team will help throughout every step of the process.

What RX VALET does:

RX VALET utilizes multiple Alternative funding sources and programs. We utilize:

- ☐ Manufacturer Prescription Assistance Programs (PAP) – Income based programs that require some member participation in the form of filling out some forms and supplying some documents.
- ☐ International Sourcing – We utilize a network of affiliated pharmacies from around the world. However, most medications are shipped from Canada. The medications are the exact same quality as if they were dispensed in the US. Many popular drugs are actually manufactured in other countries.
- ☐ Co-Pay Assistance Programs – This program is a manufacture-based program that will help us eliminate an employee's copay. RX VALET will help manage the entire process.

In summary:

RX VALET is here to help with high-cost medications. Our programs are safe, reliable and well managed. We will track all shipments, stay engaged with employees, call them for refills and request refill prescriptions from their doctor.

Save Money on Prescriptions



Reduce Your Prescription Drug Costs

Five questions you should ask your doctor if a medication is prescribed:

- Before I start the medication are there any changes to my life-style I can make to improve my condition?
- Is there a generic medication that can be prescribed for this condition? If not, is there a lower-priced brand name medication available?
- Do you have free samples of the prescribed medication available?
- Is there an effective pill-splitting dosage for the prescribed medication?
- Can you write one 30 day medication and one 90 day so I can save by using the mail order pharmacy?

Generic Prescription Drugs Can Save You Money

Generic drugs are a lower cost alternative to name brand medications. If your prescription is for a name brand medication, ask your doctor to recommend a generic alternative so that you can save money.

Refer to the following websites for a listing of generic medications at a store nearest you. Some pharmacies require enrollment in a program to receive the discount. A small membership fee may be required. Check with each pharmacy for details and costs.

Walmart CVS Target Kroger Meijer	www.walmart.com/pharmacy www.cvs.com/extracare-cvs/rxrewards www.target.com/pharmacy www.krogerhealthsavings.com www.meijer.com/pharmacy	\$4 for 30 day supply / \$10 for 90 day supply ExtraCare Pharmacy & Health Rewards Program ExtraCare Pharmacy & Health Rewards Program Rx Savings Club (membership fee required) Free Antibiotics, Select Prenatal Vitamins, Metformin & Atorvastatin Calcium
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Search Engines

Prices for prescription drugs vary widely between pharmacies, even those across the street from each other. The search engines are free to consumers and easy to use. They allow consumers to compare prices and discounts through pharmacies nearest you, drug manufacturers and other sources for the best price on that drug.

Medtipster	www.medtipster.com
GoodRx	www.goodrx.com
OneRx	www.onerx.com



Save on Laboratory Services with LabCorp

Being a savvy healthcare consumer isn't easy. The same service can often have significant differences in price from one location to another.

Take advantage of cost estimate tools when they are available, and ask for cost estimates from healthcare providers before receiving services.



LabCorp benefit for PHP TPA Services Members

You have access to several eligible lab services at no cost to you, when using LabCorp locations.

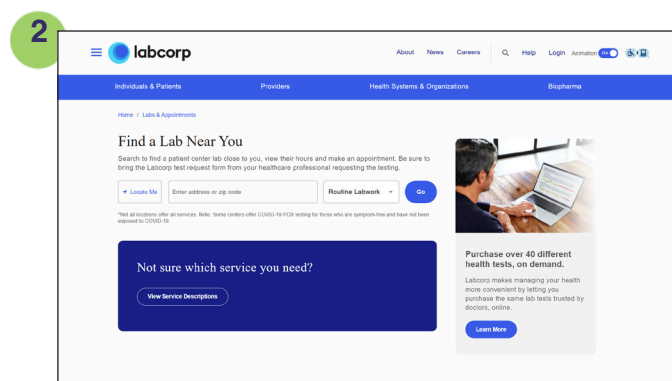
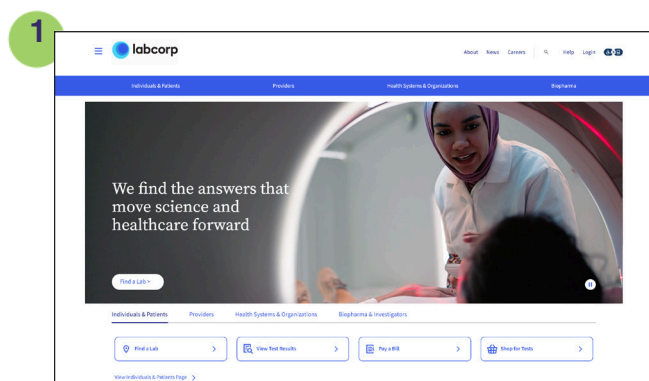
The following services may be included in *(but are not limited to)* your lab benefit.

- Blood tests
- Pregnancy tests
- Urine screenings
- Urine drug screenings *(limited to 24 screenings per year)*

Note: If you use alternative lab facilities for these services, your contract benefits will apply. Please refer to the logo on your ID card: LabCorp Gold - your member responsibility must be satisfied, and LabCorp Platinum - there is no member cost-share. If you have a high-deductible plan, you must first satisfy your plan deductible before receiving no cost LabCorp services.

Find a LabCorp location near you

Begin your search at the labcorp.com homepage to search for LabCorp locations. Select "Find a Lab" and enter your zip code or address to search for locations near you.



Contact PHP TPA Services Customer Service at 260-436-9495 or customerservice@phpni.com with any questions.



MRI . CT Scan . Ultrasound . X-Ray



Most advanced independent free-standing imaging facility in Fort Wayne

One Flat Rate

Our low pricing includes the cost of your exam and the radiologist interpretation. No hidden costs or fees.

Transparent Pricing

If you have a high deductible, part of self-insured plan, whether your insurance company pays, or you are paying out of pocket, you will know exactly how much your exam will cost upfront.

Advance Technology

High quality 1.5 Tesla MRI, 64 Slice CT, Digital X-Ray, and Ultrasound

Same or Next-day Appointments

Being a "Patient" isn't about waiting. We'll find a time that works for you.

Rapid Results

Our technology ecosystem allows for a quick report turn-around time, in most instance within 24 hours. Providers can secure access to view images anywhere and have the ability to burn onto a CD.

Expert Radiologists

All exams are interpreted by Summit Radiology's board certified, subspecialized radiologist.

Comfort and Convenience

Getting an MRI might feel like a big step. We will do our best to make it a comfortable and relaxing experience.

**If you ever have an imaging need, let your provider
know you would like to go to Direct Imaging**

An offering of DirectCare

Direct Imaging

MRI . CT Scan . Ultrasound . X-Ray

Stretch Your Healthcare Dollars



Most Affordable
Price in the
Area

* Ask about our cash based discounted price

Same-Day or Next Day Appointments

— Monday - Friday — 8am - 5pm —

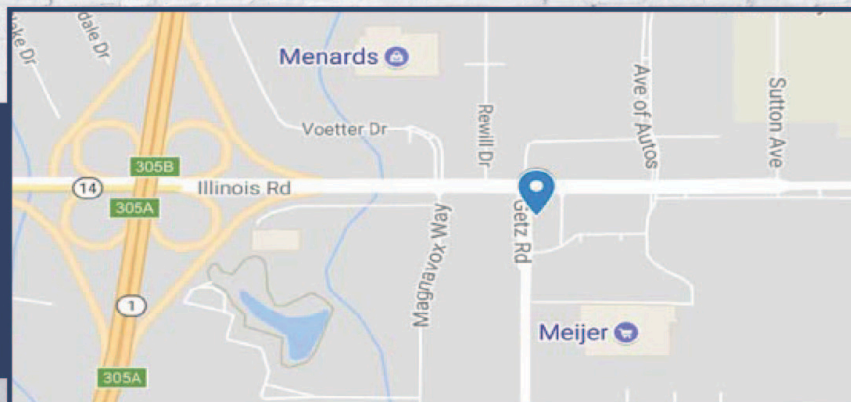
Ph: 260.212.1901

Fax: 260.999.5889

www.DirectImagingLLC.net

1355 Getz Rd. Suite-B
Fort Wayne, IN 46804

Next to Meijer on Illinois Rd.



24/7 care when you need it.

Starting December 1, 2025: Get convenient care for your health — all via phone or video. The City of Fort Wayne provides First Stop Health virtual urgent care to all retirees and up to seven family or household members!



On-demand doctor visits

Getting the care you need shouldn't be a pain. Board-certified providers are available within minutes, any time of the day, and free of charge!



Diagnosis & treatment

Get immediate support, including prescriptions when appropriate* for:

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

Activate your account



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



All employees enrolled in the City's Health Plan receive an annual WELLNESS BENEFIT to make it easier to choose a healthy lifestyle!



Annual Wellness Benefits

\$2000 ROUTINE SCREENING & TESTS

Co-pay (physicians charge only)

\$30 \$1200 deductible plan

\$0 \$3400 deductible plan

Each enrolled member receives an annual \$2000 wellness benefit! This applies to both the employee and their spouse, provided they are enrolled in the City's Health Plan.
Covered Expenses include: Routine physical examinations, preventive immunizations, flu shots (if done at the doctor's office), routine prostate examinations, routine PAP tests, routine mammograms, and all other types of wellness screenings (EBT scan, bone density, etc.)

(These charges do not track towards your \$2000 annual limit. They are paid at 100%.)

Flu shots, Shingles shots and Pneumonia shots can now be obtained through the pharmacy and paid at 100%.

Colonoscopies will be paid at 100% once every 10 years for individuals 45 or older. For higher risk individuals, colonoscopies will be covered at 100% once every 5 years beginning at the age of 40.

\$400 HEALTHY LIFESTYLE BENEFIT

Each enrolled member also receives an additional \$400 benefit for exercise, weight loss programs, physical trainer expenses, and registration fees for certified walk/runs! Employees and enrolled spouses benefits can be combined and used toward family/group memberships.

100% TOBACCO CESSATION PAID

100% coverage available for treatments including counseling, acupuncture, hypnotism, etc.

Prescription medications for the purpose of tobacco cessation now filled with a \$0 copay. Over the counter tobacco cessation products including patches, gum and nasal sprays can be purchased at the pharmacy - 30 day supply, \$0 copay. Some limitations apply.

Annual Health Screening

We conduct an annual Health Screening for employees, spouses & retirees. By participating you will receive a 10% CREDIT off your health insurance deductible for the following year! Components of the screening include:

Chem-30, Complete Blood Count, A1C, Thyroid and PSA testing

Height/Weight

Blood pressure

ALL INFORMATION IS CONFIDENTIAL

Results are mailed directly to you. It's up to you to forward your results to your doctor.



GUIDELINES FOR HEALTHY LIFESTYLE BENEFIT REIMBURSEMENTS



GYM CLUB REIMBURSEMENTS OR ANY OTHER EXERCISE RELATED MEMBERSHIP THAT HAS A MONTHLY OR ANNUAL FEE

(Gyms, Yoga/exercise studios, Tennis/Racquet Ball
Facilities, etc.)

- \$400 benefit is divided into a monthly maximum benefit of \$33.33 per employee and/or spouse (if on health plan). If the membership costs less than \$33.33 per month reimbursement will only be up to the cost of the membership.
- Must attend at least two (2) times per month to receive monthly benefit. Use the Gym Club Reimbursement Form that is available at www.cityoffortwayne.in.gov/377/City-Benefits to submit proof of attendance.
- First reimbursement submission each year must provide proof of the cost of the membership. This can be in the form of a signed contract or a copy of your pay stub if payroll deducted.

EXERCISE CLASSES/YOGA/PERSONAL TRAINERS THAT DO NOT HAVE A MONTHLY OR ANNUAL FEE (Pay per session or block of sessions)

- Will not reimburse for sessions unless you provide proof that class was attended. To submit proof of attendance use the form available at www.cityoffortwayne.in.gov/377/City-Benefits.
- Submission must include proof of cost and payment.
- Will pro-rate reimbursement if not all sessions are used in a block purchase.
- Online exercise or training programs/Apps are eligible for reimbursement but home exercise equipment such as a treadmill or bicycle is not.

CERTIFIED RUN/WALKS/CYCLING EVENTS

- Reimbursement for these events will only be after the event and proof of cost and participation is submitted.
- Fees for recreational leagues such as baseball, bowling, etc. or memberships for country clubs or neighborhood pools are not eligible for reimbursement.

WEIGHT LOSS PROGRAMS

- Monthly or annual fees will be pro-rated by number of sessions per month or year and only those sessions attended will be eligible for reimbursement. To submit proof of attendance use the form available at www.cityoffortwayne.in.gov/377/City-Benefits.
- Online weight loss programs/Apps are eligible for reimbursement.
- Food, medication and/or supplements are not eligible for reimbursement.

All reimbursements are considered taxable income and will be reimbursed on your paycheck once per month, including any reimbursement for a spouse. All submissions must be received by PHP TPA Services no later than the 20th of each month to be eligible for reimbursement the following month. You can submit claims monthly, quarterly or annually if you choose as long as the proper documentation for attendance is attached to the submission. If you have questions, please contact the Benefits Department at 427-6910 or 427-2634.



DENTAL



Dental Insurance



City of Fort Wayne offers a dental plan administered by PHP TPA Services. The following chart provides an overview and comparison of the plans. It's important to have regular dental exams and cleanings so problems are detected before they become painful and expensive.

Please refer to your Summary Plan Description for further details.

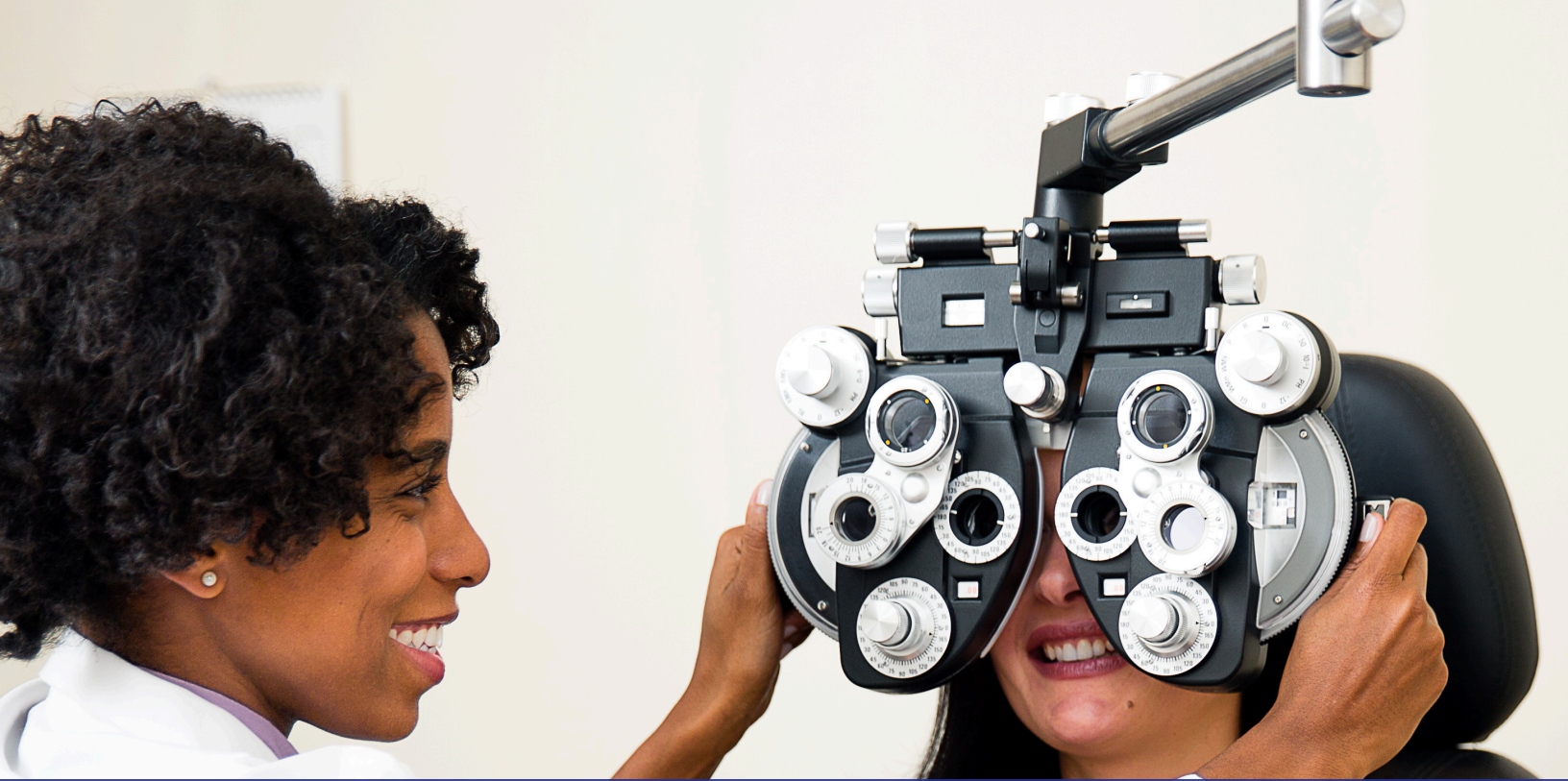
PHP TPA Services Member Portal

tpaservices.vbagateway.com



Plan Provisions	
Annual Deductible Basic & Major Services	\$50 Individual / \$150 Family
Calendar Year Maximum Basic & Major Services only (does not include preventive)	\$1,200 per individual *
Preventive Services Oral exams, prophylaxis - routine cleaning, bitewing x-ray (set of 4), complete series or panoramic x-ray, fluoride treatment, sealants, space maintainers	100%
Basic Services Amalgam and composite restoration, palliative and emergency treatment, adjunctive oral cancer screening, periodontics, endodontics, extractions including impacted wisdom teeth, re-cementing, relining and rebasing of dentures, antibiotic or prescription drugs	90%
Major Services Inlays, gold fillings, crowns, dentures and precision attachments, fixed bridgework, surgical treatments for disease of the gums and mouth tissues, implants	60%





VISION



Vision Benefit SummaryCustomer Service: **800-638-3120**Provider Locator: **800-839-3242****www.myuhcvision.com**

UnitedHealthcare Vision has been trusted for more than 40 years to deliver affordable, innovative vision care solutions to the nation's leading employers through experienced, customer-focused people and the nation's most accessible, diversified vision care network.

In-network, covered-in-full benefits (after applicable copay) include a comprehensive exam, eye glasses with standard single vision, lined bifocal, or lined trifocal lenses, standard scratch-resistant coating¹ and the frame, or contact lenses in lieu of eye glasses.

Rates

Employee	\$6.76 Monthly
Employee + Spouse	\$13.19 Monthly
Employee + Child(ren)	\$13.87 Monthly
Employee + Family	\$21.30 Monthly

Copays for in-network services

Exam	\$10.00
Materials	\$25.00

Benefit frequency

Comprehensive Exam Spectacle	Once every 12 months
Lenses	Once every 12 months
Frames	Once every 24 months
Contact Lenses in Lieu of Eye Glasses	Once every 12 months

Frame benefit

Private Practice Provider	\$130.00 retail frame allowance
Retail Chain Provider	\$130.00 retail frame allowance

Lens options

Standard scratch-resistant coating -- covered in full. Other optional lens upgrades may be offered at a discount. (Discount varies by provider.)
--

Contact lens benefit**Covered-in-full elective contact lenses⁸**

The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full (after copay). If you choose disposable contacts, up to 4 boxes are included when obtained from a network provider.

All other elective contact lenses

A \$125.00 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside the covered selection (materials copay does not apply). Toric, gas permeable and bifocal contact lenses are examples of contact lenses that are outside of our covered contacts.

Necessary contact lenses³

Covered in full after applicable copay.

Out-of-network reimbursements up to (Copays do not apply)

Exam	\$40.00
Frames	\$45.00
Single Vision Lenses	\$40.00
Bifocal Lenses	\$60.00
Trifocal Lenses	\$80.00
Lenticular Lenses	\$80.00
Elective Contacts in Lieu of Eye Glasses ²	\$125.00
Necessary Contacts in Lieu of Eye Glasses ³	\$210.00

Laser vision benefit

UnitedHealthcare Vision has partnered with the Laser Vision Network of America (LVNA) to provide our members with access to discounted laser vision correction providers. Members receive 15% off usual and customary pricing, 5% off promotional pricing at over 500 network provider locations and even greater discounts through set pricing at LasikPlus locations. For more information, call 1-888-563-4497 or visit us at www.uhclasik.com.

Sample Illustration of Savings

Cost	Employee	Employee + One	Employee + Child(ren)	Employee + Family
Annual Premium	\$78.72	\$153.72	\$161.64	\$248.16
Approx. Pre-Tax Savings (20%) ⁴	\$15.74	\$30.74	\$32.33	\$49.63
Annual Tax-Adjusted Premium	\$62.98	\$122.98	\$129.31	\$198.53
PlusCopays	\$35.00	\$70.00	\$105.00	\$140.00
Total Cost to Employee	\$97.98	\$192.98	\$234.31	\$338.53

Exam and Materials Covered by UnitedHealthcare Vision Plan	Estimated Cost Without a Vision Plan 5	Less Employee Cost	Total Savings with UnitedHealthcare Vision
Employee Exam, Single Vision & Covered-in-Full Frames	\$275.00	\$97.98	\$177.02
Employee+ One Exam, Single Vision & Covered-in-Full Frames	\$550.00	\$192.98	\$357.02
Employee+Child(ren) 6 Exam, Single Vision & Covered-in-Full Frames	\$825.00	\$234.31	\$590.69
Employee+ Family ⁷ Exam, Single Vision & Covered-in-Full Frames	\$1,100.00	\$338.53	\$761.47

¹ On all orders processed through a company owned and contracted Lab network.

² The out-of-network reimbursement applies to materials only. The fitting/evaluation is not included.

³ Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following post cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with spectacle lenses; with certain conditions of anisometropia; with certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare Vision confirming reimbursement that UnitedHealthcare Vision will make before you purchase such contacts.

⁴ Actual tax savings will depend upon your individual tax bracket.

⁵ Approximate retail value illustrated: Exam & Refraction (\$65), Single Vision Lenses (\$80), and Frames (\$130). Average retail costs may vary by provider.

⁶ For purposes of this calculation, Employee + Child(ren) is calculated with three (3) members.

⁷ For purposes of this sample calculation, Employee + Family is calculated with four (4) members.

⁸ Coverage for Covered Contact Lens Selection does not apply at Walmart or Sam's Club locations. The allowance for non-selection contact lenses will be applied toward the fitting/evaluation fee and purchase of all contacts.

Important to Remember:

- Benefit frequency based on last date of service.
- Your \$125.00 contact lens allowance is applied to the fitting/evaluation fees as well as the purchase of contact lenses. For example, if the fitting/evaluation fee is \$30, you will have \$95.00 toward the purchase of contact lenses. The allowance may be separated at some retail chain locations between the examining physician and the optical store.
- You can log on to our website to print off your personalized ID card. An ID card is not required for service, but is available as a convenience to you should you wish to have an ID card to take to your appointment.
- Out-of-Network Reimbursement, when applicable: Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement. Receipts must be submitted within 12 months of date of service to the following address: UnitedHealthcare Vision Attn. Claims Department P.O. Box 30978 Salt Lake City, UT 84130 FAX: 248.733.6060.
- At a participating network provider you will receive a 20% discount on an additional pair of eyeglasses or contact lenses. This program is available after your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UnitedHealthcare Vision shall neither pay nor reimburse the provider or member for any funds owed or spent. Not all providers may offer this discount. Please contact your provider to see if they participate. Discounts on contact lenses may vary by provider. Additional materials do not have to be purchased at the time of initial material purchase. Additional materials can be purchased at a discount any time after the insured benefit has been used.

Please note: If there are differences in this document and the Group Policy, the Group Policy is the governing document. Please consult the applicable policy/certificate of coverage for a full description of benefits, including exclusions and limitations.

The following services and materials are excluded from coverage under the Policy: Post cataract lenses; Non-prescription items; Medical or surgical treatment for eye disease that requires the services of a physician; Worker's Compensation services or materials; Services or materials that the patient, without cost, obtains from any governmental organization or program; Services or materials that are not specifically covered by the Policy; Replacement or repair of lenses and/or frames that have been lost or broken; Cosmetic extras, except as stated in the Policy's Table of Benefits.

UnitedHealthcare Vision coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06.TX and associated COC form number VCOC.INT.06.TX.



Vision Benefit Card
UnitedHealthcare®

City of Fort Wayne

Exam	Once every 12 months
Lenses	Once every 12 months
Frames	Once every 24 months
Contacts*	Once every 12 months
*(inlieuof lenses& frames)	

Exam Copay	\$10.00
Materials Copay	\$25.00



UnitedHealthcare®

www.myuhcvision.com

Customer Service: 800-638-3120

TDD for Hearing Impaired: 1.800.524.3157

Provider Locator: 1.800.839.3242

To print a personalized ID card, please logon to our website and select 'Print ID card' from the member benefits page.

With our large vision network, there's always a provider in sight

Finding a trustworthy provider who meets your lifestyle, eye care and eyewear needs is easier with UnitedHealthcare.

With UnitedHealthcare Vision Network, you can take advantage of personalized care at a local doctor or convenient evening and weekend hours at your favorite well-known retail chain or specialty online retailers.

Well-known practices and brands in our large national network include:

- 1-800 Contacts — including ExpressExam*
- Allegany Optical
- America's Best
- Bard Optical
- befitting.com
- Berkeley Eye Center
- Clarkson Eyecare
- Cohen's Fashion Optical
- Costco Optical
- Dr. Tavel Family Eye Care
- Eye Doctor's Optical Outlets
- Eyeglass World
- EyeMart Express
- For Eyes
- General Vision Services
- GlassesUSA.com
- Henry Ford OptimEyes
- JCPenney Optical
- LensCrafters — including lenscrafters.com
- Meijer Optical
- Midwest Vision Centers
- My Eye Lab
- MyEyeDr.
- National Vision
- Nationwide Vision
- Pearle Vision
- Rosin Eyecare
- Rx Optical
- Sam's Club
- SEE Inc.
- Shawnee Optical
- Shopko
- Stanton Optical
- Sterling Optical
- SVS Vision



Making it easier for you to find a provider

To find the provider who best meets your needs, sign in to myuhcvision.com or call **1-800-638-3120**.

Some providers or locations may not participate in your plan.

* For virtual prescription renewal only. ExpressExam may not be available for all vision plans and is not in all states.
continued

Well-known practices and brands in our large national network include:

- Target Optical — including targetoptical.com
- Texas State Optical
- Today's Vision
- Total Vision
- Vision Source
- Visionworks
- Vista Optical
- Walmart
- Warby Parker — including warbyparker.com
- Wisconsin Vision



See more ways to save

Keep out-of-pocket costs low by visiting uhccontacts.com or uhcglasses.com where you'll have a variety of brands and frame choices at your fingertips.

Call
1-800-638-3120

Visit
myuhcvision.com



The examples provided are for general knowledge purposes only and should not be interpreted as a preference or recommendation of any particular provider, brand, or company. We encourage members to choose providers based on their individual needs and preferences.

The company does not discriminate on the basis of race, color, national origin, sex, age or disability in health programs and activities.

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter.

To ask for help, please call 1-800-638-3120, TTY 711, Monday through Friday, 7 a.m. to 10 p.m. CST.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-800-638-3120, TTY 711.

請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請致電：1-800-638-3120, TTY 711。

All trademarks are the property of their respective owners.

UnitedHealthcare vision coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, or their affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06.TX, VPOL.13.TX or VPOL.18.TX and associated COC form number VCOC.INT.06.TX, VCOC.CER.13.TX or VCOC.18.TX. Plans sold in Virginia use policy form number VPOL.06.VA, VPOL.13.VA or VPOL.18.VA and associated COC form number VCOC.INT.06.VA, VCOC.CER.13.VA or VCOC.18.VA. This policy has exclusions, limitations and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact the company.

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Savings on blue light protection

Excessive screen time on computers, tablets and cell phones may affect vision and cause digital eye strain due to the blue light they emit.¹ And since the onset of COVID-19, people are spending an average of 13 hours per day on digital devices.² That's why we're providing savings on blue light blocking screen filters with UnitedHealthcare Vision plans.

Help employees reduce eye strain.

UnitedHealthcare Vision members have access to discounts on blue light blocking screen filters for select smartphones, tablets and laptops from Eyesafe®.

Eyesafe screen filters are designed to:

- Reduce exposure to high-energy blue light
- Help maintain color quality and luminance
- Offer a simple, lower cost option to filter blue light on existing devices
- Be easily applied to your device

Members can access the discount through myuhcvision.com

Learn more.

Contact your UnitedHealthcare representative.

Save

20%

off of the retail price on blue light blocking screen filters from Eyesafe.



OTHER SOLUTIONS

EYESAFE®

United
Healthcare
Vision

eyesafe

¹ National Institutes of Health. Research progress about the effect and prevention of blue lights on eye. 2018 ncbi.nlm.nih.gov/pmc/articles/PMC6288536/. Accessed March 29, 2021.

² Eyesafe, 2020, <https://eyesafe.com/covid-19-screen-time-spike-to-over-13-hours-per-day>

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UnitedHealthcare vision coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, or their affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06.TX or VPOL.13.TX and associated COC form number VCOC.INT.06.TX or VCOC.CER.13.TX. Plans sold in Virginia use policy form number VPOL.06.VA or VPOL.13.VA and associated COC form number VCOC.INT.06.VA or VCOC.CER.13.VA.

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Benefits designed to help protect eye health at every life stage

Eye or vision changes may be more frequent for those who are pregnant or breastfeeding — and for growing kids, too. So it's good to know your UnitedHealthcare Vision plan includes expanded benefits designed to support optimal eye health when it may be needed most.

These expanded vision benefits for those who are pregnant or breastfeeding — as well as covered children up to age 13 — are included at no additional premium cost:

- **Coverage for a second eye exam**

If you notice changes to your vision during the plan year, you can get your eyes checked a second time without paying an additional premium; standard copays apply.

- **Coverage for 1 new pair of glasses (frames and lenses)**

If your prescription changes .5 diopter* or more in a plan year, you can get new glasses without paying an additional premium; standard copays apply.

Find a nearby provider

See doctors at over 165,000 locations¹ across the country. Visit myuhcvision.com to find an eye doctor near you.

Did you know?

14% of those who are pregnant experience a change in their vision²

The importance of vision care for kids

Fewer than 15% of preschool children get an eye exam, and

Up to 75% of school vision screenings miss vision problems³

Noticing vision changes?

Schedule an eye exam for yourself or your child

**United
Healthcare**

*Refractive changes less than 0.50 diopter are considered normal variations and do not require a change in lenses.

¹ Network snapshot report (internal report), July 2023.

² Baby Center. Vision changes during pregnancy. [babycenter.com/pregnancy/your-body/vision-changes-during-pregnancy_1456567](https://www.babycenter.com/pregnancy/your-body/vision-changes-during-pregnancy_1456567). Accessed October 2023. American

³ Optometric Association. School-aged vision: 6 to 18 years of age. [aoa.org/healthy-eyes/eye-health-for-life/school-aged-vision?ss=y](https://www.aoa.org/healthy-eyes/eye-health-for-life/school-aged-vision?ss=y). Accessed July 2023.

UnitedHealthcare vision coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, or their affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06.TX, VPOL.13.TX or VPOL.18.TX and associated COC form number VCOC.INT.06.TX, VCOC.CER.13.TX or VCOC.18.TX. Plans sold in Virginia use policy form number VPOL.06.VA, VPOL.13.VA or VPOL.18.VA and associated COC form number VCOC.INT.06.VA, VCOC.CER.13.VA or VCOC.18.VA. This policy has exclusions, limitations and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact either your broker or the company.



HEALTH REIMBURSEMENT ACCOUNT

DENTAL & VISION SERVICES

1. What is a health reimbursement account (HRA)?

The City of Fort Wayne is offering a health reimbursement account (HRA) for dental and vision expenses. An HRA is an IRS-approved, tax-advantaged benefit plan that reimburses employees for out-of-pocket expenses. This benefit will only be offered to active employees. This is not available for retirees.

2. What is the annual reimbursement amount?

The City of Fort Wayne will provide up to \$500 for reimbursement of out of pocket dental and vision expenses for the plan year. There is no guarantee of this benefit being offered on an annual basis. The City of Fort Wayne will review expenses and determine the amount, if any, that will be offered in subsequent plan years.

3. Do employees have to be covered under the dental and vision plans to be eligible for reimbursement?

Yes, employees and dependents must be enrolled in the dental and vision plans in order to be eligible. If you are only enrolled in one of the plans (dental or vision), claims can only be submitted for expenses incurred under that specific plan.

4. Who owns the HRA?

According to IRS rules, the City of Fort Wayne owns the HRA. However, employees have a 90-day runout period after separation during which reimbursements can be requested for expenses incurred while employed.

5. Who can put money in the HRA?

HRA's are fully owned and funded by the City of Fort Wayne.

6. Does the HRA roll over?

No, the HRA does not roll over. However, employees have until March 30th of the following year to submit requests for reimbursement for expenses that incurred the previous year.

7. What is an eligible expense?

Eligible expenses include any out of pocket expenses not covered by the dental and vision plan up to the annual amount allowed for reimbursement under the HRA. All charges must be processed by the plans first to determine out of pocket expenses.

8. How are reimbursements processed?

Requests for reimbursements must be submitted to PHP using the HRA reimbursement form available at www.cityoffortwayne.in.gov/377/City-Benefits. Requests will be processed on the 15th and the last day of the month and must be received two days prior to that to be included. Checks will be mailed to the employee directly to their home address on file.





HSAs vs. FSAs

Health “Savings” Account HSAs

Flexible “Spending” Account FSAs

Eligibility to Contribute:

You must be on a “high-deductible” health plan that meets IRS definitions. You cannot be covered under any other “traditional” plan including a FSA, unless it is a limited purpose FSA for dental and vision services only.

You can be on a “traditional” health plan.

Account Ownership:

The HSA is a bank account owned by you, regardless of where you work. The money goes with you even if you leave your employer or change plans.

The FSA account is set up and owned by your employer so you lose any money in the account if you leave your employer.

Interest:

Able to earn interest

Does not earn interest

Annual Contribution:

In 2026, the single coverage limit is \$4,400 and the family coverage limit is \$8,750.

Limit is \$3,400

Use it or Lose It:

No. Any unused funds in your HSA at the end of the year, stay in your account indefinitely until you spend them.

There is a 3 month carryover provision that allows you to use dates of service from Jan, Feb & March to clear out the previous year’s account. Any unused funds will be forfeited.

Option to Change Contributions:

You can change your election amount when you want as long as it does not exceed the IRS limit.

You can only change your election amount if you have a qualifying event such as marriage, divorce, birth of a child, etc.

Access to Your Money:

You only have access to what has actually been deposited into your HSA to date.

You have access to your entire annual election even if you haven’t had all the money deducted from your check yet.

Claims/Approvals:

You are responsible to the IRS for spending only on Qualified Medical Expenses, and you must provide receipts if audited.

Employer approves if your spending meets IRS requirements



Health Savings Account



What is a Health Savings Account (HSA)?

An HSA is a tax-advantaged savings tool that is paired with a Qualified High Deductible Health Plan (HDHP) that can be used to pay for eligible medical expenses on a pre-tax basis. In an HSA the amounts you contribute reduce your taxable income, the interest you earn on your HSA bank account is also tax-free, and qualified medical expenses can also be paid tax free.

Who is eligible to contribute to an HSA?

In order to be eligible to contribute to an HSA, an individual must be enrolled in a qualified HDHP, and may not be enrolled in any non-HDHP plans. This means that an individual cannot be enrolled in an HDHP as well as a non-HDHP at a spouse's employer, for instance. A Health FSA can also constitute a non-HDHP, meaning that an individual may not be enrolled in both an HSA and Health FSA unless your employer offers a Limited FSA option.

You can use your HSA to pay for medical expenses for yourself, your spouse or your dependent children, even if your dependents are not covered by your HDHP. Any amounts used for purposes other than to pay for qualified medical expenses are taxable as in-come and subject to an additional 20 percent penalty. Examples of taxable expenses include:

- Your copay or coinsurance for doctor's visits
- Prescription drugs
- Medical procedures and expenses not considered qualified under federal tax law
- Over-the-counter drugs and medications without a prescription (except insulin)
- Other types of health insurance unless specifically described above
- Medicare supplement insurance premiums
- Non health-related expenses

HSA Contribution Limits	
2025	Individual - \$4,300 / Family - \$8,550
2026	Individual - \$4,400 / Family - \$8,750
HSA Catch-Up Contribution (age 55 & older)	\$1,000

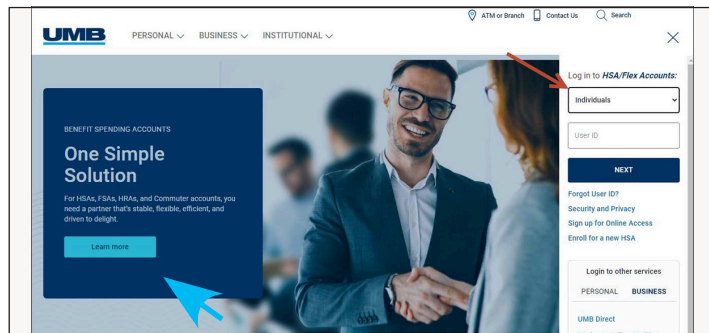


UMB HSA Online Enrollment Guide

Before you start, make sure you have the following required information available:

- Your physical address (you must have a physical address to open the account, but you may also enter a P.O. Box in "mailing address"), phone number, email address
- Your Date of Birth and Social Security number
- DOB & SS# for your spouse and/or dependents (age 18 or older) if requesting additional debit cards
- Employer verification code and program start date, provided by your employer

Note: You will not choose your beneficiary during enrollment. You will do this the first time you log on to your HSA.



Follow the six-step online enrollment process:

STEP 1: Enrollment Verification Number

Use the unique link provided by your employer, which will take you to Step 2, or go to **HSA.UMB.com** and click on **"Enroll for a new HSA"** and enter Enrollment Verification # provided by your employer.

STEP 2: Eligibility Requirements

Before proceeding, you will be prompted to confirm your eligibility to enroll in an HSA. This confirmation is performed by asking a series of questions. If you answer correctly based on the IRS requirements for eligibility, you will be able to proceed to Step 3.

STEP 3: Account Owner Personal Information

This step contains "sub-screens" that will capture all your personal information, verify your email address (UMB will send a code to your email), and allow you to input additional cardholders, if desired (spouse and/or dependents). **Note:** you must input a physical address to open your HSA or you will get an error message.

STEP 4: Review and Consent to Disclosures

In this step you will be required to open the disclosure documents and consent before you can continue. The documents will open in PDF format.

STEP 5: Verify & Submit Enrollment Information

You will be given a final opportunity to review all the information you typed in before your enrollment is transmitted to UMB for CIP review (Customer Identification Program, as required by Section 326 of the USA PATRIOT ACT, and UMB's CIP policy).

STEP 6: Confirmation

Based on the results during this session, you will get one of the following screens:

Complete Enrollment

The account is created (IF YOU GET THIS SCREEN, NO ADDITIONAL DOCUMENTATION IS REQUIRED).

Incomplete Enrollment

A message will appear indicating that UMB needs additional documentation from you (a copy of your social security card and driver's license) before we can open your account. The message provides three options (request a secure email link, fax or U.S. mail) for sending documentation copies to UMB.

Note: Your account will not be opened during this session. Your account will remain in pending status and unable to accept contributions until UMB receives the requested documentation and opens your account manually.



Once you have completed enrollment, within 5-7 business days you will receive two envelopes in the mail:

1. Your welcome letter with your account number, log on instructions, and additional information about your UMB HSA
2. HSA debit card including additional cards you ordered during your online enrollment session.

Once you receive your welcome letter, you may set up your online access, log in to your account and choose your beneficiary(s).

For questions or more information call 1.866.520.4HSA (4472).

Saving and Spending Health Savings Account Dollars

Making the most of your health savings account (HSA) means finding the right balance of saving and spending that works for you and your family right now and when life changes.

Your Account Grows in Three Ways

1. CONTRIBUTIONS

You can contribute to your account in two ways.

- **Payroll deductions.**
- **Direct contributions:** either by an electronic funds transfer from a personal account or by mailing in a personal check along with a contribution form. Friends and family members are also allowed to make contributions to your HSA on your behalf.

Your employer may provide funding to your account, too. Keep in mind that any contributions your employer makes cannot be deducted on your tax return. Employer contributions are not considered taxable income, so you don't pay taxes on them.

All contributions—yours, your employer's, friends' or family—count toward the annual maximum set by the IRS.

Contribution Limits

	Individual	Family
2025	\$4,300	\$8,550
2026	\$4,400	\$8,750

If you are age 55 or older, you may contribute an additional \$1,000.

2. INTEREST AND INVESTMENT¹ EARNINGS

If you hold a balance in your HSA, your account will grow faster to the extent that interest or earnings are credited and remain in the account. Interest can be accrued daily and paid monthly. Any balance above \$1,000 can be invested in UMB HSA Saver.[®] Go to [UMB.com/HSA](https://umb.com/HSA) for more details on current interest rates and how investment options work.



3. TAX² SAVINGS

Your account is completely tax-free,² as long as you use your funds to pay for qualified medical expenses.

- **Tax-free deposits.** Whether or not you itemize deductions on your income tax return, your HSA contributions are deductible—up to the IRS annual limit.
- **Tax-free earnings.** Your interest and any investment earnings grow tax-free.
- **Tax-free withdrawals.** The money you withdraw—today or in the future—to pay for eligible medical expenses isn't subject to taxes. That's different from a 401(k) or similar retirement plans, which are taxed when you withdraw funds.

NOTE: If you use your HSA funds to pay for goods or services that aren't qualified medical expenses, you are responsible for reporting that to the IRS, paying income taxes on the amount and a 20% penalty if you are under age 65.

INVESTMENTS IN SECURITIES THROUGH UMB HSA SAVER ARE: NOT FDIC-INSURED | MAY LOSE VALUE | NO BANK GUARANTEE

^{1,2} See reverse side for important disclosure information.

Spending Your Money

When you have a medical bill, you have a decision to make. Spend your HSA dollars? Or let your balance keep growing? Since your HSA is like a personal banking account, check that you have enough money in your account to cover a bill before you pay it. Don't have enough saved up? Pay your bill out of pocket. Then, if you still want to use your HSA dollars, you can reimburse yourself no matter when you incurred the expense.

Your debit card is sent to you once you open your account. You can request up to four additional cards at no charge. The expenses must be incurred for you, your spouse, or your eligible dependents.

When you are ready to pay a bill, follow these three steps:

- 1. Check if it's eligible.** Since your HSA is supposed to work together with your high-deductible plan, qualified eligible expenses for your HSA are typically the same bills that count toward your deductible, plus medicines, certain premiums, and some vision and dental costs. A full list of qualified expenses can be found in IRS Publication 502 at www.irs.gov.
- 2. Choose a payment method.** Here are some guidelines:

When?	Pay your Bill with:
At the pharmacy. Swipe your debit card like any other credit card when you purchase prescription drugs at a network pharmacy or access your card using your digital wallet. Your pharmacist can typically calculate your cost, including whether or not you've met your deductible, right at the time of your purchase. Also use for vision or dental care.	Debit Card/Digital Wallet (ApplePay, Samsung Pay, Garmin Pay) 
After you get a bill from a network provider. Wait for your claim to be processed so that you get the network savings and deductible credit applied to your doctor or hospital bill before you pay. Then you can give your HSA debit card number. If your provider won't accept a debit card payment, log into your account on UMB.com/HSA to have a check sent directly to your provider. Pay for your long-term care premiums this way, too.	Debit Card or Online Bill Pay 
After you've paid in full to see an out-of-network provider. Some providers may require payment at the time of service. And your total bill may vary depending on whether or not you've met your deductible. Once you are logged into your account on UMB.com/HSA , follow the instructions to "Request a Reimbursement."	Online Reimbursement 

- 3. Save your receipts.** The IRS may request that you show proof of how you used your tax-free money. Use UMB's ReceiptVault to store and organize receipts online for qualified healthcare expenses. If you use your HSA funds to pay for goods or services that aren't qualified medical expenses, you are responsible for reporting that to the IRS, paying income taxes on the amount and possibly an additional 20% penalty.

For more information about health savings accounts, see IRS Publication 969, Health Savings Accounts and Other Tax-Favored Health Plans.

INVESTMENTS IN SECURITIES THROUGH UMB HSA SAVER ARE: NOT FDIC-INSURED | MAY LOSE VALUE | NO BANK GUARANTEE

¹ UMB Investment Management selects mutual funds in various asset classes for inclusion in the UMB HSA Saver Investment Program. UMB Investment Management and UMB Custody Services are departments of UMB Bank, n.a. UMB Bank, n.a. is a wholly owned subsidiary of UMB Financial Corporation.

UMB Custody Services provides safekeeping and settlement of the mutual fund investments in the UMB HSA Saver® investment program.

² All mention of taxes is made in reference to federal tax law. Neither UMB Bank, n.a., nor its parent, subsidiaries, or affiliates are engaged in rendering tax or legal advice and this document is not intended as tax or legal advice. States can choose to follow the federal tax-treatment guidelines for HSAs or establish their own, some states tax HSA contributions. Please check with each state's tax laws to determine the tax treatment of HSA contributions or consult your tax adviser.

Quick Guide to HSAs

You own it!

The money in your HSA is always yours, even if you:

- ✓ change jobs
- ✓ switch health plans
- ✓ become unemployed
- ✓ retire

Your unused balance rolls over from year to year so you never lose the money.



Pay for the unexpected...

HSAs not only cover planned out-of-pocket costs but allow you to be better prepared financially when an unexpected injury or illness comes along.

HSA funds can be used for a variety of medical, dental, vision expenses and more.

See list of [eligible expenses](#).



Ways to Save on Taxes

1. **Tax-free deposits** Money contributed to your HSA is not taxed.
2. **Tax-free earnings** Interest and any investment earnings grow tax-free.
3. **Tax-free withdrawals** for qualified medical expenses.

How it works

To make HSA contributions you must:

- Be covered by an HSA Qualified High Deductible Health Plan (QHDHP)
- Not be enrolled in Medicare (any part)
- Not be claimed as a tax dependent on someone else's taxes
- Have no other non-permissible coverage



HSA Contributions

PLAN TYPE	2025	2026
 Individual	\$4,300	\$4,400
 Family	\$8,550	\$8,750

If you are age 55 or older, you may contribute an additional \$1,000.

Invest for the future

Learn more about [UMB HSA investments](#).

HSAs can be used similar to traditional retirement accounts, allowing you to invest money in mutual funds,² like a 401(k) or traditional IRA.

You can invest in your HSA when:

Deposit balance = \$1,000 + purchased investment amount for fund(s)



FOR MORE INFORMATION:

[UMB .com/HSA](https://umb.com/HSA)

866.520.4HSA (4472)

High-Deductible Health Plans constitute insurance products, which are not offered by UMB Bank, n.a. and are not FDIC-insured.

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² INVESTMENTS IN SECURITIES THROUGH AN HSA INVESTMENT ACCOUNT ARE: NOT FDIC-INSURED | MAY LOSE VALUE | NO BANK GUARANTEE

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Top Questions about Health Savings Accounts

These are answers to some of the most commonly asked questions about health savings accounts (HSAs).

General questions

Q1: WHAT IS A HEALTH SAVINGS ACCOUNT (HSA)?

An HSA helps you set aside money for current and future health care expenses that aren't covered by your medical plan. You can make contributions to your HSA, up to IRS limits. For 2025, the maximum contribution amount from all sources—your contributions, your employer's contributions and any other sources—is \$4,300 for individual coverage and \$8,550 for family coverage. For 2026, the maximum contribution amount will be \$4,400 for individual coverage and \$8,750 for family coverage.

Q2: WHAT TYPES OF MEDICAL PLANS ARE COMPATIBLE WITH AN HSA?

To contribute to an HSA, you must be enrolled in a high-deductible health plan (HDHP). An HDHP is a health plan that meets two requirements as specified by the U.S. Treasury Department. First, it must have an annual deductible that meets the minimum deductible amount, which is published annually. Second, the annual out-of-pocket expenses—such as deductibles, copayments and other expenses paid for by the participant—associated with the HDHP may not exceed the specified out-of-pocket maximums. Premiums (the amount you pay each month for coverage) do not count as out-of-pocket expenses.

Q3: HOW DO HSAs WORK?

You choose how much you'd like to save in your HSA each year and contributions are automatically made from your paycheck to your account. See Question 8 for additional contribution methods. You can choose to pay for current eligible medical expenses with your HSA. Or you can choose to pay for current expenses out of your pocket and save the money in your HSA to pay for future medical expenses. How you use your account and when you use it are entirely up to you.

Q4: IS MY MONEY SAFE IN AN HSA?

Yes. Your HSA deposit account balance is FDIC insured. Once you have \$1,000 saved in the HSA, you have the opportunity to open a UMB HSA Saver[®]2 investment portfolio to have the option to make investments in securities that carry various levels of risk and reward, similar to investment in a retirement savings plan.

INVESTMENTS IN SECURITIES THROUGH UMB HSA SAVER[®] ARE:
NOT FDIC-INSURED | MAY LOSE VALUE | NO BANK GUARANTEE

Q5: WHY SHOULD I CONSIDER ENROLLING IN THE HDHP WITH AN HSA?

If one or more of the following are true for you, you may want to consider making a change to a HDHP with an HSA:

- You are paying for insurance you're not using.
- You want an option to save for current and future medical expenses.
- You want to save on monthly premiums and take more control over how you use your health care benefits.
- You anticipate major health expenses such that you would reach the out-of-pocket maximum associated with the HDHP.

Eligibility and opening an account

Q6: WHO CAN OPEN AN ACCOUNT?

If you are enrolled in a high-deductible health plan, you are eligible to open an HSA as long as you:

- Are not covered by any other health plan that is not a high-deductible health plan (for example, a spouse's plan),
- Are not enrolled in Medicare benefits, and
- May not be claimed as a dependent on another person's tax return.

Account contributions

Q7: HOW MUCH CAN I CONTRIBUTE?

You can choose how much to contribute to your HSA, up to IRS limits that are set each year. For 2025, the maximum contribution amount from all sources—your contributions, your employer's contributions and any other sources—is \$4,300 for employee-only coverage and \$8,550 for family coverage. For 2026, the maximum contribution amount will be \$4,400 for individual coverage and \$8,750 for family coverage.

Q8: HOW DO I CONTRIBUTE TO THE ACCOUNT?

The Welcome Kit you will receive from UMB once you open your account outlines the different ways you can contribute to your account. The simplest way is through pretax payroll contributions, but you may also write a check or transfer money from your bank account to make a lump sum contribution to your HSA. If the money comes from your bank account instead of through payroll contributions, you may deduct the amount you contribute on your taxes since those contributions would be made with after-tax money. Your family members or others can also contribute to the account on your behalf.

Q9: I'M NEARING RETIREMENT. CAN I MAKE CATCH-UP CONTRIBUTIONS LIKE I DO TO MY RETIREMENT SAVINGS PLAN?

People age 55 and older can make a catch-up contribution each year that is over and above the allowable limit for the individual year. The catch-up contribution is \$1,000. You are able to make catch-up contributions until you become Medicare active.

Using your HSA

Q10: WHAT CAN I SPEND MY HSA BALANCE ON?

You can use your balance to pay for qualified medical expenses for you or your covered dependents (shown in IRS Publication 502). Some examples include:

- Your deductible
- Vision expenses such as contact lenses or glasses
- Dental treatments, exams or cleaning costs
- Chiropractic or acupuncture fees
- Prescription and over-the-counter drug costs
- Crutches
- Eye surgery

They don't include insurance premiums other than premiums for long-term care insurance, premiums on a health plan during any period of continuation coverage required by federal law (for example, "COBRA" coverage) or premiums for healthcare coverage while you receive unemployment compensation. You can find a full list of qualified expenses at www.irs.gov.

Q11: HOW DO I PAY FOR MEDICAL EXPENSES?

You'll receive a UMB Visa® debit card that you can use to pay for qualified expenses not covered by the high-deductible health plan. Simply swipe the card, or access your card using your digital wallet (includes: Apple Pay, Samsung Pay, and Garmin Pay) at the pharmacy or for other health-related services and the associated cost will be debited from your HSA balance. Or use your card to pay doctor's visit bills once the claim has been submitted to your insurance carrier so that you will receive the negotiated rates for services. Save your receipts, since you may need them if the IRS requests that you show proof of how you used your tax-free money. Use UMB's ReceiptVault to store and organize receipts online for qualified healthcare expenses. If you cannot use your debit card, you will pay for the expense out of your own pocket, then reimburse yourself from your HSA. If you don't have enough money in your account to pay for the entire amount of an expense (for example, if you just opened the account or the company hasn't made its full contribution yet), you can pay for a portion of that expense with your account and cover the rest with

personal funds. Once the HSA funds build and are available in the account, you can reimburse yourself from the HSA.

Q12: HOW DOES MY HSA TRACK WITH MY DEDUCTIBLE?

You may use your HSA to pay for qualified expenses including your deductible. Or you can let the HSA build up for future expenses. The choice is yours. The HSA is not a method to determine if you've met your deductible; that information is available on your medical plan provider's website or on any explanation of benefits (EOBs) that you receive from your plan.

Q13: IF I OPEN AN HSA, CAN I ALSO ENROLL IN A HEALTH CARE FLEXIBLE SPENDING ACCOUNT?

No, you cannot enroll in both. If you are married, you may not have coverage under your spouse's flexible spending account (FSA). You can only have a "limited purpose" FSA. Eligible expenses with a limited purpose FSA include most unreimbursed dental, vision and/or hearing care expenses (including expenses for your dependents), and out-of-pocket medical expenses you paid after you met your plan deductible.

Q14: WHAT ARE THE TAX IMPLICATIONS FOR PARTICIPATING IN AN HSA?

The money you save in your HSA is tax free. The money you contribute isn't taxed, nor is the money taxed as your balance grows. As long as you use the money to pay for qualified expenses, you won't pay taxes when you withdraw it either.

Q15: I HAVE AN HSA ALREADY SET UP THROUGH MY FORMER EMPLOYER. CAN I CONTRIBUTE TO THAT HSA INSTEAD WITH PAYROLL CONTRIBUTIONS?

No. However, you may transfer the balance from that HSA into your UMB HSA and continue to make pretax contributions. First, open your UMB HSA. Then decide how you'd like to transfer the funds. You have two options:

1. A direct transfer of all of the balance from one trustee to a UMB HSA.
2. A distribution of funds to the employee, who may then roll over all or part of the HSA balance into a UMB HSA.

Q16: IF I DON'T USE MY BALANCE BY THE END OF THE YEAR, WILL I LOSE IT?

No, the money in your account rolls over from year to year, so you won't lose unused money each year like you would with a flexible spending account (FSA). Best of all, your HSA balance is yours to keep even if you change health plans or changing jobs.

Questions? More details? Visit us online at UMB.com/HSA or call 866.520.4HSA (4472).

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High-Deductible Health Plans constitute insurance products, which are not offered by UMB Bank, n.a. and are not FDIC-insured.

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Pay for Qualified Medical Expenses Tax-Free!*

Your UMB Health Savings Account (HSA) is a versatile tool that allows you to decide whether to spend your money to pay for current qualified medical, dental, and vision expenses, or save your money and allow your HSA to grow for future qualified medical expenses and even retirement!

UMB offers three convenient ways for you to spend the money in your HSA:

- 1. UMB HSA Visa® debit card** For expenses such as prescriptions and over-the-counter items, you no longer have to use cash, checks or credit cards, or wait to be reimbursed for out-of-pocket expenses. Instead, you simply pull out your UMB HSA Visa debit card or access your card using digital wallet (includes: Google Pay, Apple Pay, Samsung Pay and Garmin Pay) pay—and go. Your total purchase on the card is deducted from your HSA.
- 2. HSA Online Bill Pay** For other types of expenses such as doctor's visits or hospitalization, you may need to pay your portion of the medical bill after you receive your Explanation of Benefits from your insurance provider. In these instances, you may pay with your UMB HSA Visa® debit card OR HSA Bill Pay. With Bill Pay, UMB will send a check directly to your provider from your HSA.
- 3. HSA Online Reimbursement** When you must use cash or another form of payment such as a personal credit card to pay for qualified expenses, you can easily reimburse yourself by using UMB's online banking feature, "Request a Reimbursement". Based on your direction, UMB will transfer funds from your HSA to your checking/savings account.

Qualified medical expenses are defined by IRS Code, Section 213(d) and include amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease for the purpose of affecting any structure or function of the body.

Qualified Medical, Dental and Vision Expenses**

- | | | |
|--|--|---|
| • Acupuncture | • Dentures | • Optometrist |
| • Alcoholism treatment | • Diagnostic devices (ex. blood sugar test kit) | • Orthodontia (braces) |
| • Ambulance service | • Doctor's visits | • Over-the-Counter Medicines and Supplies |
| • Annual physical examination | • Drug Addiction treatment | • Oxygen and equipment |
| • Artificial Limb | • Eye Exam | • Personal Protective Equipment (masks, hand sanitizer) |
| • Artificial Teeth | • Eyeglasses | • Pregnancy Test Kit |
| • Bandages | • Eye surgery (including laser vision correction surgery) | • Pre-natal vitamins |
| • Body Scan | • Fertility procedures | • Prescription medication |
| • Braille books and magazines (partial cost) | • Guide dog or other service animal | • Psychiatric care |
| • Breast Reconstruction Surgery following a mastectomy | • Health plan premiums during a period in which you are receiving government unemployment compensation | • Psychologist Special home for intellectually and developmentally disabled |
| • Capital expenses for special equipment installed in home for main purpose of medical care (ex: support bars, exit ramps, lowering of cabinets) | • Hospital Services | • Special Education |
| • Car special equipment for disabilities | • Insulin and Supplies | • Stop-Smoking programs |
| • Chiropractor | • Laboratory Fees | • Telephone and Television for hearing impaired |
| • Christian Science Practitioner | • Long Term Care insurance premiums | • Therapy |
| • COBRA premiums | • Medicare Part A, B, C, or D | • Transplant (ex: heart, kidney) |
| • Contact lenses and supplies | • Menstrual products (pads and tampons) | • Transportation for medical care |
| • COVID-19 Testing and Treatment | • Nursing home (non-custodial) | • Vasectomy and sterilization |
| • Crutches | • Nursing services | • Wheelchair |
| • Dental treatments (ex. cleanings, fluoride treatments, x-rays, fillings, extractions) | • Operations | • X-rays |

Non-Qualified Medical Expenses**

Expenses for items that are merely beneficial to the general health of an individual are not considered qualified expenses. If you use your HSA to pay for expenses that are not qualified you will have to pay income tax and a 20 percent penalty on the non-qualified purchase amount. Below are some examples of non-qualified expenses:

- Childcare for normal, healthy baby
- Controlled substances that violate federal law
- Cosmetic dentistry
- Cosmetic surgery
- Dancing lessons
- Electrolysis
- Funeral expenses
- Hair transplant
- Health club dues
- Household help
- Late Charges
- Maternity clothes
- Nutritional supplements and vitamins
- Swimming lessons
- Teeth Whitening
- Vacation
- Veterinary Fees

Documentation of Qualified Medical Expenses

The IRS requires that you keep itemized receipts to document your qualified withdrawals. Those receipts must include the date of service and the type of expense. Use UMB's ReceiptVault to store and organize receipts online for qualified healthcare expenses. Bankcard statements and estimates of expenses are not permitted.

Whose expenses are qualified?

Your qualified tax-free HSA* withdrawals may be for expenses incurred by you, your spouse or your eligible dependents (Section 152 of the federal tax code), regardless of whether or not they are covered under your health plan.

When are expenses qualified?

Your expenses are qualified when they are incurred after your HSA is established. Then, even if you lose eligibility to make contributions to your HSA, you may still spend the money you have accrued in your HSA to pay for qualified medical expenses, tax-free.*

Questions?

Contact your helpful UMB Healthcare Services customer support agent at 866.520.4HSA (4472), or visit us at HSA.UMB.com.

INVESTMENTS IN SECURITIES THROUGH UMB HSA SAVER ARE: NOT FDIC-INSURED | MAY LOSE VALUE | NO BANK GUARANTEE

NOTE: HSA funds used to pay for non-qualified medical expenses are subject to income taxes on the amount and a possible additional 20% penalty, if you're under age 65.

** This document is not intended to provide legal or tax advice. Neither UMB Bank n.a., nor its parent, subsidiaries, or affiliates are engaged in rendering tax or legal advice. Consult your tax adviser, or visit irs.gov, for information. All mention of taxes is made in reference to federal tax law. State taxes may vary.*

*** The list provides examples of eligible and ineligible medical expenses. This list is not all-inclusive. The IRS may modify its list of eligible expenses from time to time. For additional details, contact your tax professional or see IRS tax publication 502: Medical and Dental Expenses on the web at www.irs.gov/publications.*

2026 HSA Contribution Rules*

for Married Couples

		Spouse 1**				
		No Coverage	Self-Only non-HDHP	Self-Only HDHP	Family non-HDHP	Family HDHP
Spouse 2**	No Coverage	Neither person is eligible to contribute to an HSA.	Neither person is eligible to contribute to an HSA.	Spouse 1 is eligible and may contribute up to \$4,400 ¹ , but spouse 2 is not eligible to contribute to an HSA.	Neither person is eligible to contribute to an HSA.	Spouse 1 is eligible and may contribute up to \$8,750 ¹ , but spouse 2 is not eligible to contribute to an HSA unless he/she is covered under spouse 1's HDHP. In this case the maximum combined contribution of \$8,750 ² must be divided between them based on agreement. ³
	Self-Only non-HDHP	Neither person is eligible to contribute to an HSA.	Neither person is eligible to contribute to an HSA.	Spouse 1 is eligible and may contribute up to \$4,400 ¹ , but spouse 2 is not eligible to contribute to an HSA.	Neither person is eligible to contribute to an HSA.	Spouse 1 is eligible and may contribute up to \$8,750 ¹ , but spouse 2 is not eligible to contribute to an HSA.
	Self-Only HDHP	Spouse 2 is eligible and may contribute up to \$4,400 ¹ , but spouse 1 is not eligible to contribute to an HSA.	Spouse 2 is eligible and may contribute up to \$4,400 ¹ , but spouse 1 is not eligible to contribute to an HSA.	Both people are eligible to have their own HSA and the maximum that can be contributed to each HSA is \$4,400 ² .	Neither is eligible to contribute unless spouse 2 is not covered under spouse 1's non-HDHP plan. In that case spouse 2 may contribute up to \$4,400 ¹ to an HSA.	Both people are eligible and treated as if they have family coverage. Their maximum combined contribution of \$8,750 ² must be divided between them based on agreement. ³
	Family non-HDHP	Neither person is eligible to contribute to an HSA.	Neither person is eligible to contribute to an HSA.	Neither is eligible to contribute unless spouse 1 is not covered under spouse 2's non-HDHP plan. In that case spouse 1 may contribute up to \$4,400 ¹ to an HSA.	Neither person is eligible to contribute to an HSA.	Spouse 1 is only eligible to contribute up to \$8,750 ¹ if he/she is not covered under spouse 2's non-HDHP plan. Spouse 2 is not eligible to contribute to an HSA.
	Family HDHP	Spouse 2 is eligible and may contribute up to \$8,750 ¹ , but spouse 1 is not eligible to contribute to an HSA unless he/she is covered under spouse 2's HDHP. In this case the maximum combined contribution of \$8,750 ² must be divided between them based on agreement. ³	Spouse 2 is eligible and may contribute up to \$8,750 ¹ , but spouse 1 is not eligible to contribute to an HSA.	Both people are eligible and treated as if they have family coverage. The maximum combined contribution of \$8,750 ² must be divided between them based on agreement. ³	Spouse 2 is only eligible to contribute up to \$8,750 ¹ if he/she is not covered under spouse 1's non-HDHP plan. Spouse 1 is not eligible to contribute to an HSA.	Both people are eligible and treated as if they have family coverage. The maximum combined contribution of \$8,750 ² must be divided between them based on agreement. ³

NOTE: This contribution chart assumes neither spouse is enrolled in Medicare or Medicaid.

High-Deductible Health Plans constitute insurance products, which are not offered by UMB Bank, n.a. and are not FDIC-insured.

* All mention of taxes is made in reference to federal tax law. Neither UMB Bank, n.a., nor its parent, subsidiaries, or affiliates are engaged in rendering tax or legal advice and this document is not intended as tax or legal advice. States can choose to follow the federal tax-treatment guidelines for HSAs or establish their own, some states tax HSA contributions. Please check with each state's tax laws to determine the tax treatment of HSA contributions or consult your tax adviser.

**Revenue Ruling 2013-17, 2013-38 IRB. The IRS has ruled that same-sex couples who were legally married in a jurisdiction that recognizes same-sex marriages will be treated as married for all federal tax purposes, even if the couple lives in a jurisdiction that does not recognize the validity of same-sex marriages. For federal tax purposes, the terms "spouse", "husband and wife", "husband", and "wife" include an individual married to a person of the same sex if the individuals are lawfully married under state law, but that such terms do not include individuals who have entered into a registered domestic partnership, civil union, or similar formal relationship recognized under state law that is not denominated as a marriage under that state law.

¹ An additional catch-up contribution of \$1,000 may be contributed if the eligible accountholder is over age 55.

² If both spouses are over 55, they may each contribute up to an additional \$1,000, to their own respective HSAs.

³ See IRS Notice 2008-59, Q&A #17

• An HDHP is an HSA-qualified high deductible health plan, with minimum annual deductibles and annual out-of-pocket maximums, as defined and indexed annually by U.S. Treasury Department.

• Family HDHP coverage is any level of coverage other than self-only coverage. Family coverage does not have to include the other spouse.

• Individuals who are eligible for a partial year and plan to contribute the annual maximum must remain eligible for the following calendar year to avoid additional taxes and penalties.

• Regardless of the applicable HSA contribution scenario (above), HSA funds may always be spent to pay for qualified medical expenses for the accountholder, spouse and federal tax dependents.

Flexible Spending Accounts



A Flexible Spending Account (FSA) is a valuable benefit, which can save you significant tax dollars. Your contribution is deducted from your paycheck on a pretax basis and put into the FSA. When you incur expenses, you can access the funds in your account to pay for eligible expenses. The Flexible Spending Accounts are administered by HealthEquity. This chart shows the eligible expenses and how much you can contribute each year.

Account Type	Eligible Expenses	Annual Contribution Limits
Health FSA (General Purpose)	• Deductible and coinsurance amounts • Office visits and ER co-payments • Prescription drug co-payments • Durable medical equipment • Hearing aids • Dental treatment and orthodontia • Eyeglasses and contact lenses • Contact lens cleaning supplies • Laser vision corrective surgery • OTC items not containing medicine (band aids)	\$3,400
Health FSA (Limited Purpose)	• Dental treatments (fillings, crowns) • Orthodontia • Prescriptions eyeglasses • Contact lenses • Contact lens cleaning supplies	\$3,400
Dependent Care FSA	Dependent care expenses including day care, after school programs for children under age 13 or elder care programs so you can work or attend school full-time.	Maximum contribution is \$7,500 per year (\$3,750 if married and filing separate tax returns).

Important Information about FSAs

- Your FSA elections are effective from January 1 through December 31.
- Claims for reimbursement must be submitted by March 31 of the following year.
- There is a 2.5 month Grace Period following the end of the plan year. You can continue to incur expenses for reimbursement.
- Please plan your contributions carefully. Any unused money remaining in your account(s) will be forfeited.
- This is known as the “use it or lose it” rule and it is governed by Internal Revenue Service regulations.
- FSA elections do not automatically continue from year to year; you must actively enroll each year.
- You can only change your FSA contribution amount if you experience a qualified status change.

Online Member Portal: Activating your account

Your online member portal is a powerful tool that gives you access to all the account management features. To Access, visit my.healthequity.com. The portal is best experienced using Internet Explorer (8.0 or later) and current versions of Firefox, Chrome, and Safari.

Using the HealthEquity member portal, you can check your balance, review transactions, view insurance claims, invest in mutual funds, pay providers and submit for reimbursement online.

Scan the QR code to access the
online member portal guide



Member portal login

Logging into your member portal is easy. Simply follow steps below to access your HealthEquity account.



Scan the QR code to access the member activation portal



Logging in to your portal for the first time

- 1 Go to my.healthequity.com.
Under 'Are you a member logging in for the first time?' click 'Create username and password.'
- 2 Verification code
You will be prompted to do a verification step by entering the code on the screen.
- 3 Find your account
Enter the information requested on the "Find your account" screen.
- 4 Verify your identity
Enter the information asked for on the "Verify your identity" screen.
- 5 Set up login
You will be prompted on the "Set up your login" Screen:
Pick a user/login name of at least six characters with numbers and letter on the "set up your login" screen.
Choose a password of at least eight characters with an uppercase letter, a lowercase letter and a number.
- 6 Enter email
On the "Your email settings" screen, enter your email address.
- 7 Agree to terms of service
Click the box to agree to the term of the website and save the agreement.

Logging in to your portal after your first login

- 1 Go to my.healthequity.com.
- 2 Log in with the username and password you created the first time you logged in.

Discover more ways to connect health and wealth.

866.346.5800 | HealthEquity.com

Investments are subject to risk, including the possible loss of the principal invested, and are not FDIC or NCUA insured, or guaranteed by HealthEquity, Inc. Investing through the HealthEquity investment platform is subject to the terms and conditions of the Health Savings Account Custodial Agreement and any applicable investment supplement. Investing may not be suitable for everyone and before making any investments, review the fund's prospectus. HealthEquity does not provide legal, tax or financial advice.

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LIFE & DISABILITY

Life Insurance and Disability



Basic Life and AD&D Insurance

Life insurance is an important part of your financial wellbeing, especially if others depend on you for support. The company provides basic life and accidental death and dismemberment insurance at **no cost** to you.

Employee Basic Life/AD&D Insurance

Class 1: All Active Members of the Patrolmen's Benevolent Association (PBA)	Life: 1 x BAE* up to \$150,000 max AD&D: 3 x BAE* up to \$350,000 max
Class 2: All Active Firefighters	Life: 1 x First Class Firefighters annual earnings up to \$150,000 max AD&D: 1 x First Class Firefighters annual earnings up to \$150,000 max
Class 3: All Active Members of the Fraternal Order of Police (FOP)	Life: 1 x BAE* plus longevity bonus up to \$150,000 max AD&D: 3 x BAE* plus longevity bonus up to \$450,000 max
Class 4: All Other Active Employees	Life: 1 x BAE* up to \$150,000 max AD&D: 1 x BAE* up to \$150,000 max

Voluntary Life and AD&D Insurance

You may choose to purchase additional life and AD&D coverage for yourself and your dependents at affordable group rates. Rates are based on age and the coverage level chosen.

Voluntary Life/AD&D Insurance for you

Employee

- Increments of \$10,000 to a max of \$500,000
- Guaranteed issue up to \$200,000

Voluntary Life/AD&D Insurance for your dependents

Spouse

- Increments of \$5,000 up to \$250,000 max, not to exceed 50% of employee amount
- Guaranteed issue up to \$30,000

Child(ren)*

- Increments of \$2,000 up to \$10,000 maximum

*Birth to age 26

Disability Insurance

Disability insurance provides income replacement should you become disabled and unable to work due to a non-work-related illness or injury. The company provides both short-term disability coverage and long-term disability coverage at **no cost** to you.

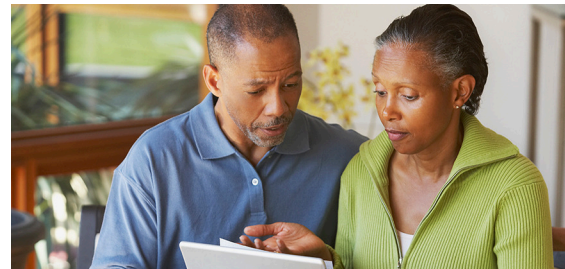
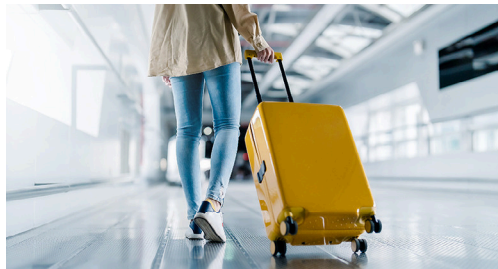
Coverage	Eligible Expenses
Short-Term Disability	• 60% of your weekly earnings to a maximum of \$1,500 per week for the first 12 weeks of disability • Benefits begin on the 8th day for accident or sickness • Pregnancy is covered the same as any other illness
Long-Term Disability (Police/Fire Excluded)	• 60% of your monthly earnings to a maximum of \$5,000 per month • Benefits begin if you are disabled and are unable to work for more than 90 days

Voluntary Life/AD&D Note: Evidence of Insurability (EOI) will be required if an employee did not enroll during their initial new hire waiting period or if an employee/dependent wants to purchase coverage over the Guaranteed Issue Amount.



Support for life's challenges

Symetra SupportSM
Services to help when needed most
FOR GROUP LIFE INSURANCE



Symetra SupportSM

Whether you're managing a loved one's final affairs, are in need of assistance while traveling, or looking for guidance on how to resolve identity theft, Symetra SupportSM services offered through your group coverage provides direct assistance when you need it most.



TravelAssistance



Peace of mind while you travel in over 180 countries

Identity Theft Assistance



Security for your finances with timely fraud resolution

Beneficiary Assistance



Relief and support during a difficult and stressful time

EstateGuidance[®]



Simplify your estate planning and reduce costs

Travel Assistance, Identity Theft Assistance and Beneficiary Assistance are provided by On Call International, and EstateGuidance[®] is provided by ComPsych[®]. You have access to these services through your Symetra Group Life Insurance coverage.

Continued >

Travel Assistance

24/7 emergency help



Travel Assistance can give you peace of mind while you're traveling abroad.

Emergencies happen. When they happen far from home, it's comforting to know there's a team of multilingual professionals standing by to help. Travel Assistance offers a variety of 24-hour-a-day services in more than 180 countries and territories worldwide—and each one is just a phone call or live chat away.

Who's eligible for Travel Assistance?

You and your eligible dependents are considered qualified for all services provided by Travel Assistance.

You can receive pre-trip information at any time.

All other services take effect when you're on a trip 100 miles or more from home lasting 90 days or less.



Travel Assistance features

Medical assistance and transport services*

- **Medical, mental health, dental and pharmacy referrals:** Referrals are provided upon request in the given geographic area locations, where possible.
- **24-hour nurse help line:** Clinical assessment, education and general health information provided upon request.
- **Medical evacuation:** Emergency medical transportation with medical supervision from one facility to another when deemed medically necessary to receive more appropriate treatment.
- **Medical monitoring:** Provided during hospitalization to determine if care is appropriate or if evacuation is required.
- **Medically necessary repatriation:** Once stabilized and deemed fit to travel, medically necessary transportation is provided to return to place of residence for follow up care or to recover. If discharged and deemed fit to travel unescorted, Travel Assistance can arrange transportation to return to the original location or to home if the reason for travel has ended.
- **Prescription replacement assistance:** Consults with the prescribing physician and, if possible, arrangements to send replacement medications or eyeglasses.
- **Coordination of benefits:** Travel Assistance requests health and travel insurance information and attempts to coordinate benefits during an active assistance case.
- **Repatriation of remains:** In the event of death while traveling, all necessary government authorizations and a container appropriate for transportation will be coordinated and arranged, as well as return home of the remains for burial.
- **Vehicle return:** In the event of a death or medical transport that prevents you and your traveling companions from driving your vehicle home, Travel Assistance will procure a driving service to return your vehicle or fly someone you trust to drive it back home.
- **Emergency pet boarding/return:** If you're traveling with your pets and your medical condition leaves you hospitalized and your pet unattended, Travel Assistance will arrange for your pet's return home or for boarding until your discharge.

Emergency travel assistance services*

- **Emergency travel arrangements for visit by family or friend:** If hospitalized, Travel Assistance will arrange travel and suitable hotel accommodations for a person of choice to join.
- **Return of dependent children:** If dependent(s) are present but left unattended as a result of a medical transportation, hospitalization or death, Travel Assistance will make arrangements to return them home, including a non-medical escort as required.
- **Return of traveling companion:** If a medical emergency or death occurs, Travel Assistance will arrange one-way economy airfare to return a companion to their original departure point.

Other key travel assistance services

- **Pre-trip travel information** including visa, passport, inoculation, and immunization requirements, cultural information, embassy and consulate referrals, foreign exchange rates and travel advisories. Get up-to-date information regarding health risks, travel restrictions and weather conditions for destinations worldwide.
- **Emergency message relay** to and from friends, relatives and business associates.
- **24/7 assistance with emergency travel arrangements**, including a change of airline, hotel and car rental reservations, once a trip has started.
- **Help locating and replacing lost or stolen items** like luggage, documents and personal possessions.
- **Legal services are available** if arrested while traveling internationally or in need of legal services. Travel Assistance will arrange for an initial telephone consultation with an attorney without charge.
- **Translation assistance:** Interpreters are available via phone for translation needs. On Call will also provide referrals for local interpreters and written translation assistance.

*This is only an outline of the plan's features. All services must be arranged and provided by On Call International. Please review your Description of Coverage carefully to understand all the services available to you as well as any terms, conditions and limitations.

Continued ➤

Identity Theft Assistance

Direct access to 24/7 support if your identity is stolen



Identity Theft Assistance can help secure your finances and aid in identity theft resolution.

Identity theft is a rising concern and it can happen to anyone. Identity Theft Assistance offers you peace of mind by providing you with step-by-step coaching and assistance to help you resolve identity theft.

Who's eligible for the Identity Theft Assistance?

You and your eligible dependents are considered qualified for all services provided by Identity Theft Assistance. Identity thefts discovered prior to enrollment in a Symetra Group Life Insurance plan are not eligible for services.

If you think your identity has been stolen

Just pick up the phone—24 hours a day, seven days a week—and call On Call International at **(978) 651-9223** if you're in the U.S. or Canada, or **1-833-808-0253** from anywhere else in the world.

Identity Theft Assistance features



Fraud assistance and credit review

- **Three-bureau fraud alert placement assistance:** Upon your request, the three major credit bureaus will be contacted to inform them your credit cards were lost/stolen so that the incident is reported.



Document replacement and financial assistance

- **Lost wallet assistance:** If your debit/credit cards are lost or stolen, Identity Theft Assistance will contact your bank and credit card companies with you on the phone to alert them that the cards were lost or stolen and could be compromised. They'll also provide information to help you replace lost items such as your driver's license and Social Security card.
- **Lost passport replacement:** In the event your passport is lost or stolen, Identity Theft Assistance will assist you in securing an emergency passport replacement, including locating the nearest consulate or embassy if the loss occurs while you're traveling.
- **Emergency cash advance assistance:** If needed, Identity Theft Assistance will assist you in obtaining cash advances from family or friends.

Tips to remember to protect your identity

- ✓ Carry only one or two debit or credit cards.
- ✓ Bring only the ID information that you'll actually need.
- ✓ Keep your passport safe while traveling—make copies, store it in a safe place, and if stolen or lost, report it immediately.
- ✓ Do not carry your Social Security card in your wallet.
- ✓ If your purse or wallet is stolen, immediately report it to the police.
- ✓ Notify your financial institution if your debit or credit card is lost or stolen.



Continued >

Beneficiary Assistance

A helping hand after a loss



Beneficiary Assistance can offer some relief and support during an already stressful time.

Managing a loved one's final affairs can be overwhelming.

The amount of time and effort needed to process the loss and close an estate can make an already stressful time even more difficult. Beneficiary Assistance can offer some relief and provide compassionate guidance to help with paperwork, notifications and the time-consuming details of managing a loved one's final affairs.

Who's eligible for Beneficiary Assistance?

You and your eligible dependents, as well as any beneficiaries named under your group life insurance policy with Symetra, qualify for all services provided by Beneficiary Assistance.



Beneficiary Assistance features



Empathetic guidance

Dedicated coordinators are available 24/7 to provide compassionate professional assistance to:

- **Answer questions.**
- **Offer guidance** on obtaining death certificates or, if applicable, a Consular Report of Death Abroad documentation.
- **Provide beneficiaries with information** regarding local grief counseling services.
- **Assist beneficiaries** with researching local estate planning and/or probate resources.
- **Provide translation services**, if needed, for non-English speakers.



Funeral home referrals

We understand it can be difficult to know how to handle the death of a loved one. When placed in a situation where you have to find a funeral home, you may feel overwhelmed. That's where Beneficiary Assistance can help. You can rely on the experienced beneficiary assistance coordinators to provide referrals to a local funeral home and to funeral director services, if needed.

If the loss of a loved one occurs during travel, Beneficiary Assistance can also help facilitate communication between funeral homes to help with bringing your loved one home as quickly as possible.



Fraud resolution

A deceased's identity is an attractive target for criminals—and may be relatively easy to obtain. Specialists will help you to take actions to protect your loved one's identity and will lend you a hand if their identity is stolen.

These services include:

- **Three-bureau fraud alert placement assistance:** Assist the beneficiary to report the death, suppress the deceased's credit report and/or request the credit bureaus to freeze/close the account.
- **Help filing a police report**, if fraud has occurred.

You may also call Symetra at 1-877-377-6773 for your beneficiary checklist—a resource guide for additional support after a loved one's death.

EstateGuidance®

Planning for the future



EstateGuidance® can simplify the process of planning your estate and save you money.

We understand that drafting a will and a living will can be a complicated and expensive process.

EstateGuidance® eliminates the hassle and high costs with a simple, secure and affordable online tool.

A better way to secure your legacy

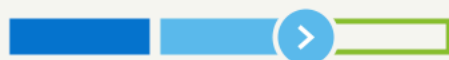
- > **It's fast:** Preparing an online will using EstateGuidance® takes less than 60 minutes, on average.
- > **It's convenient:** Prepare these documents when and where it works for you.
- > **It's easy to use:** EstateGuidance® provides step-by-step guidance to simplify the process.
- > **It grows with you:** Once you create documents online, you can make unlimited free revisions, as needed, to keep them up-to-date.
- > **It's legally binding:** You can rely on these documents to be legally enforceable.

To get started:

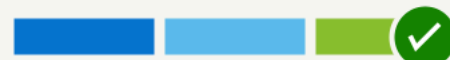
Complete an easy-to-understand questionnaire and then print, review and sign your documents, which are created in real time.



Visit www.EstateGuidance.com



Enter your promotional code:
SymetraLife



Choose any of the options in
the drop-down menu.

EstateGuidance® features

Create last will and testament, living will, health care power of attorney, financial power of attorney, and/or final arrangement documents for, at most, a minor additional fee.



Last will and testament

\$14.99

A last will and testament (“will”) is the cornerstone of an estate plan. A will ensures that your assets are distributed in accordance with your wishes after your death. A will also allows you to name an executor and a guardian to take care of your children if they are minors. Printing and mailing is available for an additional \$9.99.



Financial power of attorney

No additional cost

A financial power of attorney form allows you, the principal, to name someone else, the agent, to make financial decisions for you.



Final arrangements

\$9.99

This document is intended to give your surviving family members, friends and associates guidance regarding your last wishes and to ensure that they can properly honor your memory. Final arrangements allow you to specify your burial or cremation preferences and personalize your obituary, funeral or memorial service. It leads you through the process by asking thoughtful questions and providing detailed educational resources.

We know that plans may change as you progress through different stages of your life. Be assured that EstateGuidance® will be with you every step of the way. Once you create these documents online, you can make unlimited free revisions, as needed, to keep them up-to-date.



Living will and health care power of attorney

\$14.99

A living will is an advanced directive that documents your wishes regarding medical treatment and nutrition in the event of terminal illness, coma or vegetative state. Printing and mailing of a living will is available for an additional \$9.99.

A health care power of attorney, included at no additional cost with a living will, allows you to give a trusted family member or friend the power to make medical decisions on your behalf should you become unable to make such decisions.



Access your Symetra Support services



To access your On Call Travel Assistance, Identity Theft Assistance and Beneficiary Assistance services:

Just pick up the phone—24 hours a day, seven days a week—and call On Call International at (978) 651-9223 if you're in the U.S. or Canada, or 1-833-808-0253 from anywhere else in the world. You may also reach On Call International via text at 1-844-302-5131.



To access your ComPsych EstateGuidance® program:
Visit www.EstateGuidance.com and enter the promotional code **SymetraLife**. Choose any of the options in the drop-down menu.



Symetra Life Insurance Company is the parent company of First Symetra National Life Insurance Company of New York (collectively, "Symetra"). Symetra Life Insurance Company does not solicit business in the state of New York and is not authorized to do so. Each company is responsible for its own financial obligations.

Group benefits are insured by Symetra Life Insurance Company, 777 108th Avenue NE, Suite 1200, Bellevue, WA 98004. Benefits may not be available in all states and are not available in any U.S. territory. Policies may be subject to exclusions, limitations, reductions and termination of benefit provisions.

In New York, group policies are insured by First Symetra National Life Insurance Company of New York, New York, NY. Mailing address P.O. Box 34690, Seattle, WA 98124.

Travel Assistance, Identity Theft Assistance and Beneficiary Assistance programs are provided by On Call International. EstateGuidance® is provided by ComPsych. Symetra SupportSM may not be available in all states. On Call and ComPsych are not affiliated with Symetra Life Insurance Company or any of its subsidiaries. EstateGuidance® is a registered trademark of ComPsych Corporation.

While Symetra has arranged for your access to these third-party EAP services, Symetra is not responsible for the provision of such services nor are we liable for the failure of the provision of the same. Further, we are not liable to you for the negligent provision of such goods and/or services by third-party service providers.

Symetra SupportSM is a service mark of Symetra Life Insurance Company.



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www.symetra.com/ny

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ComPsych

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Support for life's many challenges

Symetra SupportSM

Employee assistance, well-being coaching and computerized cognitive behavioral therapy programs

GROUP DISABILITY VALUE-ADDED SERVICES





Employee assistance program

Helping you cope with the present and plan for the future

When life gets tough, it's helpful to have someone in your corner to listen. That's what you get from DisabilityGuidanceSM—an employee assistance program that offers confidential counseling for individuals covered under a Symetra group disability policy.

Program highlights

Up to five confidential sessions with a counselor, financial planner or attorney are available to you and your eligible family members each calendar year.² An additional five sessions are available if you have a covered disability claim. Sessions are per household and may be divided among the three types of professionals. While all types of sessions can be held over the phone, in-person counseling sessions are also available. These services are included in the overall premium, so no additional payment is required to use the program.

Confidential counseling

Trained counselors with a master's or doctorate degree are just a phone call away to provide you the right resources for stress, anxiety, job pressures, substance abuse, and grief and loss.

Legal support

Talk to an attorney about legal concerns such as divorce, real estate transactions, debt and bankruptcy, and more.

Need legal representation?

A general guidance consultant will refer you to a qualified attorney in your area for a free 30-minute consultation. Any customary legal fees after that are reduced by 25%.

Financial information and resources

A certified public accountant or financial planner can provide financial information and guidance on topics like debt, taxes, retirement planning, credit card or loan problems, and more.

Online resources and tools

Get trusted, professional information about relationships, work, school, children, wellness, legal or financial issues, and more.

Turn to GuidanceResources® online for:

- Timely articles, tutorials, videos and self-assessments.
- “Ask the Expert” personal responses to your questions.
- Searches for child or elder care, attorneys and financial planners.

Planning for the future

A will is one of the most important legal documents you can have. It ensures that you'll control who gets your property, who will be your children's guardian, and who manages your estate when you die.

EstateGuidance® makes it easy to create a simple, customized, legally binding will by offering:

- Convenient online access to will documentation tools.
- Simple-to-follow instructions guiding you through the will-generation process.
- Online support from licensed attorneys, if needed.
- The ability to make revisions at no cost.

Wills as low as \$14.99.* Printing and mailing services are available for an additional fee. Contact ComPsych for additional information.

*Prices may be subject to change.

First-time users, follow these simple steps:

- ① Go to guidanceresources.com and click “Register.”
- ② Provide your organization web ID: **SYMETRA**
- ③ Create a user name and password.

If you have problems registering or logging in, send an email to memberservices@compsych.com or call [1-888-327-9573](tel:1-888-327-9573).

Call ComPsych with any questions or for more information:

Phone: **1-888-327-9573**

TDD: **1-800-697-0353**



Well-being coaching

Breaking through life's barriers

In today's high-pressure world, work-life challenges and making space to work on our well-being often combine to overwhelm us. Available Jan. 1, 2026, well-being coaching can help you find the balance you need to overcome these challenges and achieve your goals.

A certified coach will work one-on-one with you to reduce personal roadblocks and risks—addressing health and well-being holistically—before they evolve into long-term, costly problems. The services are available via phone or video sessions and cover a wide variety of issues.

Call ComPsych anytime at [1-888-327-9573](tel:1-888-327-9573) to request an appointment with a personal coach and get the support you need to live a healthier, more balanced life.

Supported issues include:

- Burnout
- Balancing competing needs
- Developing self-compassion
- Goal setting
- Building resiliency
- Time management
- Coping with stress
- Finding motivation
- Improving sleep



Computerized cognitive behavioral therapy (CCBT)

Digital self-care tools, available anytime, anywhere

Available Jan. 1, 2026, computerized cognitive behavioral therapy (CCBT) gives you access to interactive programs, skill-building tools and inspirational resources to help you:

- Reduce personal roadblocks
- Eliminate stress and anxiety
- Overcome mental barriers

All the while, the program tracks your progress and keeps you motivated on your journey to a better you. CCBT is much more than a mindfulness or mediation app. The dynamic, digital content is grounded in evidence-based techniques—such as cognitive behavioral therapy, mindfulness and positive psychology—and is curated by skilled psychologists.

Log on to guidanceresources.com and click the icon for digital self-care tools to get started today!

Focus areas include:

- Anxiety
- Depression
- Mindfulness
- Sleep improvement
- Stress
- Resilience
- Positive thinking
- Low self-esteem

Languages available:

- CanadianFrench
- Chinese
- English
- French
- German
- Italian
- Japanese
- Portuguese
- Spanish



www.symetra.com
www.symetra.com/ny

Symetra® is a registered servicemark of Symetra Life Insurance Company.

For more information, visit www.guidanceresources.com.

Symetra Life Insurance Company is the parent company of First Symetra National Life Insurance Company of New York (collectively, "Symetra"). Symetra Life Insurance Company does not solicit business in the state of New York and is not authorized to do so. Each company is responsible for its own financial obligations.

Group benefits are insured by Symetra Life Insurance Company, 777 108th Avenue NE, Suite 1200, Bellevue, WA 98004. In New York, group benefits are insured by First Symetra National Life Insurance Company of New York, New York, NY. Mailing address: P.O. Box 34690, Seattle, WA 98124.

DisabilityGuidanceSM, GuidanceResources®, EstateGuidance®, well-being coaching and CCBT are provided by ComPsych. Value-added services may not be available in all states. ComPsych is not affiliated with Symetra Life Insurance Company or any of its subsidiaries.

Symetra SupportSM is a service mark of Symetra Life Insurance Company.

¹

In California, counseling sessions are limited to three sessions in a six-month period.

² Once you are enrolled in a group disability income insurance policy from Symetra Life Insurance Company.



Group Hospital Insurance



How does it work?

Group Hospital Insurance helps covered employees and their families cope with the financial impacts of a hospitalization. You can receive benefits when you're admitted to the hospital for a covered accident, illness or childbirth.

Why is this coverage so valuable?

- The money is payable directly to you — not to a hospital or care provider. The money can also help you pay the out-of-pocket expenses your medical plan may not cover, such as co-insurance, co-pays and deductibles.
- You get accessible rates when you buy this coverage at work.
- The cost is conveniently deducted from your paycheck.
- The benefits in this plan are compatible with a Health Savings Account (HSA).
- You may take the coverage with you if you leave the company or retire. You'll be billed directly.

Be Well Benefit

Every year, each family member who has Hospital coverage can also receive \$50 for getting a covered Be Well screening test, such as:

- Annual exams by a physician include sports physicals, wellchild visits, dental and vision exams
- Screenings for cancer, including pap smear, colonoscopy
- Cardiovascular function screenings
- Screenings for cholesterol and diabetes
- Imaging studies, including chest X-ray, mammography
- Immunizations including HPV, MMR, tetanus, influenza

Eligibility: All employees not eligible in another group

Who can get coverage?

You:	If you're actively at work.
Your spouse:	Can get coverage as long as you have purchased coverage for yourself.
Your children:	Dependent children newborn until their 26th birthday, regardless of marital or student status

Employee must purchase coverage for themselves in order to purchase spouse or child coverage. Employees must be legally authorized to work in the United States and actively working at a U.S. location to receive coverage.

How much does it cost?

Your semi-monthly premium	
You	\$7.50
You and your spouse	\$16.11
You and your children	\$11.11
Family	\$19.72

Coverage may vary by state. See exclusions and limitations.
This plan has a childbirth limitation. See disclosures for more information.
If enrolling, and eligible for Medicare (age 65+; or disabled) the Guide to Health Insurance for People with Medicare is available at <https://www.medicare.gov/publications/02110-medigap-guide-health-insurance.pdf>

Hospital		
Hospital Admission	Payable for a maximum of 1 day per year	\$1,000
Hospital Daily Stay	Payable per day up to 365 days	\$100
ICU Daily Stay	Payable per day up to 30 days	\$200

Exclusions and Limitations

Hospital insurance filed policy name is Group Hospital Indemnity Insurance Policy. The definition of hospital does not include certain facilities. See your contract for details.

Active employment

You are considered in active employment if, on the day you apply for coverage, you are being paid regularly for the required minimum 30 hours per week and you are performing the material and substantial duties of your regular occupation. Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. New employees have a 30 day waiting period to be eligible for coverage. Please contact your plan administrator to confirm your eligibility date.

Childbirth Limitation

We will not pay benefits due to Childbirth for any Insured within the first nine months after the Insured's Coverage Effective Date.

Childbirth or Complications of Pregnancy will be covered to the same extent as any other Covered Sickness.

Exclusions and limitations

We will not pay benefits for a claim that is caused by, contributed to by, or resulting from any of the following:

- committing or attempting to commit a felony;
- being engaged in an illegal occupation or activity;
- injuring oneself intentionally or attempting or committing suicide, whether sane or not;
- active participation in a riot, insurrection, or terrorist activity. This does not include civil commotion or disorder, Injury as an innocent bystander, or Injury for self-defense;
- participating in war or any act of war, whether declared or undeclared;
- Combat or training for combat while serving in the armed forces of any nation or authority, including the National Guard, or similar government organizations;
- being intoxicated;
- a Covered Loss that occurs while an Insured is legally incarcerated in a penal or correctional institution;
- elective procedures, cosmetic surgery, or reconstructive surgery unless it is a result of organ donation, trauma, infection, or other diseases;
- treatment for dental care or dental procedures, unless treatment is the result of a Covered Accident;
- any Admission or Daily Stay of a newborn Child immediately following Childbirth unless the newborn is Injured or Sick;
- voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician; and
- Mental or Nervous Disorders. This exclusion does not include dementia if it is a result of:
- stroke, Alzheimer's disease, trauma, viral infection; or
- other conditions which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.

Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

End of employee coverage

If you choose to cancel your coverage under this certificate, your coverage will end on the first of the month following the date you provide notification to your Employer.

Otherwise, your coverage under this certificate ends on the earliest of:

- the date the Policy is cancelled by us or your Employer;
- the date you are no longer in an Eligible Group;
- the date your Eligible Group is no longer covered;
- the date of your death;
- the last day of the period any required premium contributions are made; or
- the last day you are in Active Employment.

However, as long as premium is paid as required, coverage will continue in accordance with the Continuation of your Coverage During Absences provision or if you elect to continue coverage for you under Portability of Hospital Indemnity Insurance.

We will provide coverage for a Payable Claim that occurs while you are covered under this certificate.

THIS INSURANCE PROVIDES LIMITED BENEFITS

This coverage is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law. Insureds in some states must be covered by comprehensive health insurance before applying for hospital insurance.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form GHIP16-1 and Certificate Form GHIC16-1 or contact your Unum representative.

Unum complies with applicable civil union and domestic partner laws.

Underwritten by: Unum Insurance Company, Portland, Maine

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Accident Insurance



How does it work?

Accident Insurance pays a set benefit amount based on the type of injury you have and the type of treatment you need. It covers accidents that occur on and off the job. And it includes a range of incidents, from common injuries to more serious events.

Why is this coverage so valuable?

It can help you with out-of-pocket costs that your medical plan doesn't cover, like co-pays and deductibles. You'll have base coverage without medical underwriting. The cost is conveniently deducted from your paycheck. You can keep your coverage if you change jobs or retire. You'll be billed directly.

What's included?

Be Well Benefit

Every year, each family member who has Accident coverage can also receive \$50 for getting a covered Be Well screening test, such as:

- Annual exams by a physician include sports physicals, well-child visits, dental and vision exams
- Screenings for cancer, including pap smear, colonoscopy
- Cardiovascular function screenings
- Screenings for cholesterol and diabetes
- Imaging studies, including chest X-ray, mammography
- Immunizations including HPV, MMR, tetanus, influenza

Who can get coverage?

You	If you're actively at work*
Your spouse	Can get coverage as long as you have purchased coverage for yourself.
Your children	Dependent children from birth until their 26th birthday, regardless of marital or student status.

*Employees must be legally authorized to work in the United States and actively working at a U.S. location to receive coverage. See Schedule of benefits for a complete listing of what is covered.

How much does it cost?

Your Semi-monthly premium	Option 1
You	\$5.41
You and your spouse	\$9.64
You and your children	\$10.94
Family	\$15.18

SCHEDULE OF BENEFITS

Accidental Death and Dismemberment

AD&D	
Employee	\$25,000
Spouse	\$12,500
Children	\$6,250
Common Carrier	
Benefit can pay if the insured individual is injured as a fare-paying passenger on a common carrier (examples include mass transit trains, buses and planes)	
Employee	\$25,000
Spouse	\$12,500
Children	\$6,250
Dismemberment	
Both Feet	\$25,000
Both Hands	\$25,000
One Foot	\$12,500
One Hand	\$12,500
Thumb and Index Finger of the same Hand	\$6,250
Coma	
Coma	\$5,000
Loss of Use	
Hearing	\$12,500
Sight of one Eye	\$12,500
Sight of both Eyes	\$25,000
Speech	\$12,500
Paralysis	
Uniplegia	\$6,250
Hemi/Paraplegia	\$12,500
Triplegia	\$18,750
Quadriplegia	\$25,000

Hospitalization

Admission	\$1,000
Admission – Hospital ICU	\$1,000
Daily Stay (amount)	\$200
Daily Stay – Hospital ICU (amount)	\$200
Short Stay	N/A
Domestic Steerage	N/A

Injury

Organized Sports	N/A
Burns	
2nd Degree Burns - At least 5%, but less than 20% of skin surface	\$500
2nd Degree Burns - 20% or greater of skin surface	\$1000
3rd Degree Burns - Less than 5% of skin surface	\$2,000

Injury

3rd Degree Burns - At least 5%, but less than 20% of skin surface	\$5,000
3rd Degree Burns - 20% or greater of skin surface	\$10,000
Concussion	
Concussion	\$200
Connective Tissue Damage	
One Connective Tissue (tendon, ligament, rotator cuff, muscle)	\$90
Two or more Connective Tissues (tendon, ligament, rotator cuff, muscle)	\$150
Dislocations	
Knee joint (other than patella)	\$1,650
Ankle bone or bones of the foot (other than toes)	\$1,650
Hip joint	\$3,375
Collarbone (sternoclavicular)	\$825
Elbow joint	\$500
Hand (other than Fingers)	\$500
Lower Jaw	\$500
Shoulder	\$500
Wrist joint	\$500
Collarbone (acromioclavicular and separation)	\$325
Finger or Toe (Digit)	\$150
Kneecap (patella)	\$500
Incomplete Dislocation - Payable as a % of the applicable Dislocations benefit	25%
Eye Injury	
Eye Injury	\$200
Fractures	
Skull (except bones of Face or Nose), Depressed	\$4,500
Hip or Thigh (femur)	\$3,375
Skull (except bones of Face or Nose), Non-depressed	\$2,250
Vertebrae, body of (other than Vertebral Processes)	\$1,350
Leg (mid to upper tibia or fibula)	\$1,350
Pelvis	\$1,350
Bones of the Face or Nose (other than Lower Jaw, Mandible or Upper Jaw, Maxilla)	\$675
Upper Arm between Elbow and Shoulder (humerus)	\$675
Upper Jaw, Maxilla (other than alveolar process)	\$675

Injury

Ankle (lower tibia or fibula)	\$450
Collarbone (clavicle, sternum) or Shoulder Blade (scapula)	\$450
Foot or Heel (other than Toes)	\$450
Forearm (olecranon, radius, or ulna), Hand, or Wrist (other than Fingers)	\$450
Kneecap (patella)	\$450
Lower Jaw, Mandible (other than alveolar process)	\$450
Vertebral Processes	\$450
Rib	\$450
Tailbone (coccyx), Sacrum	\$450
Finger or Toe (Digit)	\$225
Chip Fracture - Payable as a % of the applicable Fractures benefit	25%
Same bone maximum incurred per accident	1 Fracture
Maximum payable multiplier for multiple bones	2 Times
Internal Injuries	
Internal Injuries	\$200
Lacerations	
No Repair	\$50
Repair Less than 2 inches	\$150
Repair At least 2 inches but less than 6 inches	\$300
Repair 6 inches or greater	\$600
Loss of a Digit	
One Digit (other than a Thumb or Big Toe)	\$750
One Digit (a Thumb or Big Toe)	\$1,125
Two or more Digits	\$1,500
Knee Cartilage	
Knee Cartilage (Meniscus) Injury	\$150
Ruptured or Herniated Disc	
One Disc	\$150
Two or more Discs	\$250
Recovery	
At-Home Care	\$75
Physician Follow-Up Visits	\$50
Physician Follow-Up Maximum Visits	2
Prescription Drug	\$25
Prescription Benefit Incidence per covered accident	1 Per Insured
Rehabilitation or Subacute Rehabilitation Unit	\$50
Behavior Health Therapy	N/A

SCHEDULE OF BENEFITS

Recovery

Behavior Health Therapy visits	N/A
Therapy Services (chiro, speech, PT, occ)	\$25
Therapy Services Maximum Days	15

Surgery

Dislocations	
Dislocation, Surgical Repair - Payable as a % of the applicable Injury benefit	100%
Anesthesia	
Epidural or Regional Anesthesia	\$100
General Anesthesia	\$250
Connective Tissue	
Exploratory without Repair	\$100
Repair for One Connective Tissue	\$800
Repair for Two or more Connective Tissues	\$1,200
Eye Surgery	
Eye Surgery, Requiring Anesthesia	\$300
Fractures	
Fractures, Surgical Repair - Payable as a % of the applicable Injury benefit	100%
Surgical Repair same bone maximum incurred per accident	1 Fracture
Surgical Repair same bone maximum payable multiplier for multiple bones	2 Times
General Surgery	
Abdominal, Thoracic, or Cranial	\$1,500
Exploratory	\$150
Incidence per covered accident	1 Per Insured
Hernia Surgery	
Hernia Surgery	\$150
Knee Cartilage	
Knee Cartilage (Meniscus) Exploratory without Repair	\$150
Knee Cartilage (Meniscus) with Repair	\$750
Outpatient Surgical Facility	
Outpatient Surgical Facility	\$300
Ruptured or Herniated Disc Surgery	
Exploratory without Repair	\$125
One Disc	\$675
Two or more Discs	\$1,000

Treatment

Organized Sports	N/A
Ambulance	
Air	\$1,500
Ground	\$200
Durable Medical Equipment	
Tier 1 (arm sling, cane, medical ring cushion)	\$65
Tier 2 (bedside commode, cold therapy system, crutches)	\$125
Tier 3 (back brace, body jacket, continuous passive movement, electric scooter)	\$250
Emergency Dental Repair	
Dental Crown	\$450
Dental Extraction	\$150
Filling or Chip Repair	\$115
Imaging	
Tier 1: X-rays or Ultrasound	\$50
Tier 2: Bone Scan, CAT, CT, EEG, MR, MRA, or MRI	\$150
Medical Imaging Incidence allowance covered accident per Tier	1 Per Insured Per Tier
Lodging	
Lodging (per night)	\$200
Prosthetic Device	
One Device or Limb	\$1,000
Two or more Devices or Limbs	\$2,000
Skin Grafts	
For Burns - Payable as a % of the applicable Burn benefit	50%
Not Burns - Less than 20% of skin surface	\$375
Not Burns - 20% or greater of skin surface	\$750
Treatment	
Emergency Room Treatment	\$125
Injections to Prevent or Limit Infection (tetanus, rabies, antivenom, immune globulin)	\$50
Pain Management Injections (epidural, cortisone, steroid)	\$150
Transfusions	\$500
Transportation (per trip)	\$150
Family Care	N/A
Pet Boarding (per day)	N/A
Treatment in a Physician's Office or Urgent Care Facility (initial)	\$50

Active employment

You are considered in active employment if, on the day you apply for coverage, you are being paid regularly for the required minimum 20 hours each week and you are performing the material and substantial duties of your regular occupation. Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. New employees have a 0 day waiting period to be eligible for coverage. Please contact your plan administrator to confirm your eligibility date.

If enrolling, and eligible for Medicare (age 65+; or disabled) the Guide to Health Insurance for People with Medicare is available at www.medicare.gov/sites/default/files/2022-03/02110-medigap-guide-health-insurance.pdf.

Effective date of coverage

Coverage becomes effective on the first day of the month in which payroll deductions begin.

Exclusions and limitations

We will not pay benefits for a claim that is caused by, contributed to by, or resulting from any of the following:

- committing or attempting to commit a felony;
 - being engaged in an illegal occupation or activity;
 - injuring oneself intentionally or attempting or committing suicide, whether sane or not;
 - active participation in a riot, insurrection, or terrorist activity. This does not include civil commotion or disorder, Injury as an innocent bystander, or Injury for self-defense;
 - participating in war or any act of war, whether declared or undeclared;
 - combat or training for combat while serving in the armed forces of any nation or authority, including the National Guard, or similar government organizations;
 - a Covered Loss that occurs while an Insured is legally incarcerated in a penal or correctional institution;
 - elective procedures, cosmetic surgery, or reconstructive surgery unless it is a result of organ donation, trauma, infection, or other diseases;
 - any Sickness, bodily infirmity, or other abnormal physical condition or Mental or Nervous Disorders, including diagnosis, treatment, or surgery for it;
 - infection. This exclusion does not apply when the infection is due directly to a cut or wound sustained in a Covered Accident;
 - experimental or investigational procedures;
 - operating any motorized vehicle while intoxicated;
 - operating, learning to operate, serving as a crew member of any aircraft or hot air balloon, including those which are not motor-driven, unless flying as a fare paying passenger;
 - jumping, parachuting, or falling from any aircraft or hot air balloon, including those which are not motor-driven;
 - travel or flight in any aircraft or hot air balloon, including those which are not motor-driven, if it is being used for testing or experimental purposes, used by or for any military authority, or used for travel beyond the earth's atmosphere;
 - practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received;
 - riding or driving an air, land or water vehicle in a race, speed or endurance contest; and
 - engaging in hang-gliding, bungee jumping, sail gliding, parasailing, parakiting, or BASE jumping.
- The Accidental Death and Dismemberment Benefits are also subject to the following Exclusions. We will not pay benefits for a claim that is caused by, contributed to by, or resulting from any of the following:

- being intoxicated; and
- voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician.]

Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

Termination of employee coverage

If you choose to cancel your coverage your coverage ends on the first of the month following the date you provide notification to your employer. Otherwise, your coverage ends on the earliest of the:

- the date this policy is canceled by Unum or your employer;
- the date you are no longer in an eligible group;
- the date your eligible group is no longer covered;
- the date of your death;
- the last day of the period any required premium contributions are made;
- the last day you are in active employment.

However, as long as premium is paid as required, coverage will continue

- in accordance with the Continuation of your Coverage during Absences provision; or
- if you elect to continue coverage for you, your Spouse, and Children under Portability of Accident Insurance.

We will provide coverage for a Payable Claim that occurs while you are covered under this certificate

Accident Insurance

THIS IS A LIMITED BENEFITS POLICY

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to certificate form GAC16-1 et al. and GAC16-2, GAC16-2-IL, GAC16-3-NH, GAC16-2-OH, and GAC16-2-UT. Policy Form GAP16-1 et al. in all states, GAP16-3-NH in New Hampshire or contact your Unum representative.

Unum complies with state civil union and domestic partner laws when applicable.

Underwritten by: Unum Insurance Company, Portland, Maine

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Group Critical Illness Insurance



How does it work?

If you're diagnosed with an illness that is covered by this insurance, you can receive a lump sum benefit payment. You can use the money however you want.

Why is this coverage so valuable?

- The money can help you pay out-of-pocket medical expenses, like deductibles.
- You can use this coverage more than once.
Even after you receive a payout for one illness, you're still covered for the remaining conditions and for the reoccurrence of any critical illness with the exception of skin cancer. The reoccurrence benefit can pay 100% of your coverage amount. Diagnoses must be at least 180 days apart or the conditions can't be related to each other.

What's covered?

Critical Illnesses	
• Heart attack • Stroke • Major organ failure • End-stage kidney failure	• Coronary artery disease • Major (50%): • Coronary artery bypass graft or valve replacement • Minor (10%): • Balloon angioplasty or stent placement
Cancer conditions	
• Invasive cancer — all breast cancer is considered invasive • Non-invasive cancer (25%)	• Skin cancer — \$500
Progressive diseases	Supplemental conditions
• Amyotrophic Lateral Sclerosis (ALS) • Dementia, including Alzheimer's disease • Multiple Sclerosis (MS) • Parkinson's disease • Functional loss	• Loss of sight, hearing or speech • Benign brain tumor • Coma • Permanent Paralysis • Occupational HIV, Hepatitis B, C or D Paid at 25% • Infectious Diseases

Why should I buy coverage now?

- It's more accessible when you buy it through your employer and the premiums are conveniently deducted from your paycheck.
- Coverage is portable. You may take the coverage with you if you leave the company or retire. You'll be billed at home.

Be Well Benefit

Every year, each family member who has Critical Illness coverage can also receive \$50 for getting a covered Be Well Benefit screening test, such as:

- Annual exams by a physician include sports physicals, well-child visits, dental and vision exams
- Screenings for cancer, including pap smear, colonoscopy
- Cardiovascular function screenings
- Screenings for cholesterol and diabetes
- Imaging studies, including chest X-ray, mammography
- Immunizations including HPV, MMR, tetanus, influenza

Who can get coverage?

You:	Choose \$10,000, \$20,000 or \$30,000 of coverage with no medical underwriting to qualify if you apply during this enrollment.
Your spouse:	Spouses can only get 50% of the employee coverage amount as long as you have purchased coverage for yourself.
Your children:	Children from live birth to age 26 are automatically covered at no extra cost. Their coverage amount is 50% of yours. They are covered for all the same illnesses plus these specific childhood conditions: cerebral palsy, cleft lip or palate, cystic fibrosis, Down syndrome and spina bifida. The diagnosis must occur after the child's coverage effective date.

Semi-monthly costs		
Age	Employee coverage: \$10,000 Spouse coverage: \$5,000 Be Well benefit: \$50	
	Employee	Spouse
under 25	\$1.52	\$1.22
25 - 29	\$1.82	\$1.37
30 - 34	\$2.22	\$1.57
35 - 39	\$2.72	\$1.82
40 - 44	\$3.62	\$2.27
45 - 49	\$5.02	\$2.97
50 - 54	\$7.32	\$4.12
55 - 59	\$10.12	\$5.52
60 - 64	\$14.52	\$7.72
65 - 69	\$21.32	\$11.12
70 - 74	\$31.77	\$16.35
75 - 79	\$44.42	\$22.67
80 - 84	\$61.17	\$31.05
85+	\$95.97	\$48.45

Semi-monthly costs		
Age	Employee coverage: \$30,000 Spouse coverage: \$15,000 Be Well benefit: \$50	
	Employee	Spouse
under 25	\$2.72	\$1.82
25 - 29	\$3.62	\$2.27
30 - 34	\$4.82	\$2.87
35 - 39	\$6.32	\$3.62
40 - 44	\$9.02	\$4.97
45 - 49	\$13.22	\$7.07
50 - 54	\$20.12	\$10.52
55 - 59	\$28.52	\$14.72
60 - 64	\$41.72	\$21.32
65 - 69	\$62.12	\$31.52
70 - 74	\$93.47	\$47.20
75 - 79	\$131.42	\$66.17
80 - 84	\$181.67	\$91.30
85+	\$286.07	\$143.50

Semi-monthly costs		
Age	Employee coverage: \$20,000 Spouse coverage: \$10,000 Be Well benefit: \$50	
	Employee	Spouse
under 25	\$2.12	\$1.52
25 - 29	\$2.72	\$1.82
30 - 34	\$3.52	\$2.22
35 - 39	\$4.52	\$2.72
40 - 44	\$6.32	\$3.62
45 - 49	\$9.12	\$5.02
50 - 54	\$13.72	\$7.32
55 - 59	\$19.32	\$10.12
60 - 64	\$28.12	\$14.52
65 - 69	\$41.72	\$21.32
70 - 74	\$62.62	\$31.77
75 - 79	\$87.92	\$44.42
80 - 84	\$121.42	\$61.17
85+	\$191.02	\$95.97

Active employment: You are considered in active employment if, on the day you apply for coverage, you are being paid regularly for the required minimum 30 hours each week and you are performing the material and substantial duties of your regular occupation. Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. New employees have a 30 day waiting period to be eligible for coverage. Please contact your plan administrator to confirm your eligibility date.

If enrolling, and eligible for Medicare (age 65+; or disabled) the Guide to Health Insurance for People with Medicare is available at <https://www.medicare.gov/publications/02110-medigap-guide-health-insurance.pdf>

Your paycheck deduction will include the cost of coverage and the Be Well Benefit. Actual billed amounts may vary.

Exclusions and limitations

We will not pay benefits for a claim that is caused by, contributed to by, or occurs as a result of any of the following:

- committing or attempting to commit a felony; being engaged in an illegal occupation or activity; injuring oneself intentionally or attempting or committing suicide, whether sane or not; active participation in a riot, insurrection, or terrorist activity. This does not include civil commotion or disorder, injury as an innocent bystander, or injury for self-defense; participating in war or any act of war, whether declared or undeclared; combat or training for combat while serving in the armed forces of any nation or authority, including the National Guard, or similar government organizations; voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician; being intoxicated; and a Date of Diagnosis that occurs while an Insured is legally incarcerated in a penal or correctional institution.

Additionally, no benefits will be paid for a Date of Diagnosis that occurs prior to the Coverage Effective Date. Date of diagnosis must be after the coverage effective date.

End of employee coverage

If you choose to cancel your coverage your coverage ends on the first of the month following the date you provide notification to your employer. Otherwise, your coverage ends on the earliest of the: date this policy is canceled by Unum or your employer; date you are no longer in an eligible group; date your eligible group is no longer covered; date of your death; last day of the period any required premium contributions are made; or last day you are in active employment.

However, as long as premium is paid as required, coverage will continue in accordance with the Continuation of your Coverage during Absences provision or if you elect to continue coverage for you, your Spouse, and Children under Portability of Critical Illness Insurance.

Unum will provide coverage for a payable claim that occurs while you are covered under this certificate.

Unum complies with applicable civil union and domestic partner laws.

THIS INSURANCE PROVIDES LIMITED BENEFITS

This coverage is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law. Insureds in some states must be covered by comprehensive health insurance before applying for this coverage.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Certificate Form GCIC16-1 and Policy Form GCIP16-1 or contact your Unum representative.

Underwritten by: Unum Insurance Company, Portland, Maine

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GROUP WHOLE LIFE INSURANCE and Living Care Benefits



Give yourself protection for a lifetime

Many people buy life insurance to provide financial protection for those left behind. What if your life insurance could also provide benefits if you suffer from a permanent health condition and you require ongoing care from a family member or professional caregiver?

Value of Whole Life insurance

- Permanent Life insurance
- Living Care benefits for chronic illnesses
- Guaranteed premiums and death benefits
- Accumulates cash value¹
- Payroll-deducted premiums
- Coverage can be taken with you if you change jobs or retire, billed directly to you at home

Atlantic American's Whole Life & Living Care plan combines the guarantees of permanent life insurance with the benefits of living care protection. Our living care benefits can assist you when you need to take care of ongoing expenses that arise from a chronic medical condition.

How can Living Care benefits help?



¹Access to cash values through borrowing or partial surrenders will reduce the policy's cash value and death benefit, increase the chance the policy will lapse, and may result in a tax liability if the policy terminates before the death of the insured.

This hybrid life product is ideal if you want to:

- Leave a death benefit to loved ones after you die
- Provide benefits for the costly expenses associated with care, particularly over long periods of time
- Lifelong coverage through retirement with no increase in premiums

GROUP WHOLE LIFE INSURANCE

The ABC's of Living Care¹ benefits

Long-term chronic illnesses can have a significant impact on an individual's quality of life, both physically and financially. These types of illnesses often require ongoing medical treatment and care, which can be costly and financially devastating for individuals and their families. Atlantic American's Whole Life plan allows you to access a portion of your life insurance benefits while living. We call this Living Care.

You may not have a long-term illness now, but let's consider how you may use a hybrid life plan.

Living Care¹ ABC's

Example Election:

Whole Life
\$70,000



Living Care
6.25% up to 32 months



Death
Restoration

A

What if you need care for a long-term illness?

You are able to use our Living Care benefit with a maximum monthly benefit \$4,375, for up to 32 months.

When you pass away, your beneficiary still receives a Death Benefit of 50%, or \$35,000.



Use it all and get restored

B

What if you need care for a brief period of time?

You could have a serious illness that leaves you needing care for a brief period. You use only \$28,000 for your care, before passing away.

The remainder of your policy, \$42,000, is paid to your beneficiary as a death benefit.



Use some and leave some

C

You could pass away, without ever needing care

The entire \$70,000 face amount of your policy will be paid as a **death benefit** to your beneficiaries.



Keep it all as a legacy

¹The Living Care Benefit is an acceleration of the death benefit and is not Long-Term Care Insurance. It begins to pay after 90 days of confinement or services, and to qualify you must meet conditions of eligibility for benefits. Pre-existing condition limitation may apply. Living Benefits may not be available in all states or may be named differently. Please consult your policy for complete details. This hypothetical example does not guarantee or predict actual performance. This is an example for illustrative purposes only. Actual policy amounts and payments will depend on benefits purchased, death and living benefits.

GROUP WHOLE LIFE INSURANCE



Summary of Benefits

AtlanticAmerican Employee Benefits' Group Whole Life insurance plan includes the benefits listed below. Each benefit is subject to conditions for payment as detailed in the certificate.

PLAN INFORMATION

Available To	ISSUE AGES	BENEFIT AMOUNT
Employee	18-70	Up to \$100,000 in \$10,000 increments
Spouse Coverage*	18-65	Up to \$30,000, in \$10,000 increments - up to 100% of employee election. Based on spouse age.
Dependent Coverage*	15 days - age 25	\$10,000 - up to 100% of employee election. Term rider continues to age 26 at which point they may choose to convert to an individual policy, up to 5x the Child's coverage amount, on a guarantee issue basis.

ADDITIONAL PLAN DETAILS

Portability	Included
-------------	----------

RIDERS

Employee	Accelerated Death Benefit for Terminal Illness Rider - Insured can receive up to 50% of elected face amount during their life when there are diagnosed with a terminal illness that leaves them with a life expectancy of 12 months or less.
	Waiver of Premium Rider - Plan premiums are waived during disability period when insured has been disabled for 6 months. Included on issue ages 18-65; terminates at age 70.
	Accelerated Death Benefit for Chronic Illness Rider with Extension of Benefits Rider - Provides a 6.25% monthly benefit, up to 200% of certificate face amount.
Spouse	Restoration of Benefits Rider - Restores 50% of the death benefit for the beneficiary in the event the Acceleration for Chronic Illness Rider is exhausted.
	Accelerated Death Benefit for Terminal Illness Rider
	Accelerated Death Benefit for Chronic Illness Rider with Extension of Benefits Rider - 6.25% monthly benefit, up to 200% of certificate face amount.
Dependent(s)	Restoration of Benefits Rider - Restores 50% of the death benefit for the beneficiary in the event the Acceleration for Chronic Illness Rider is exhausted.
	Children's Term Rider

All benefit amounts are Guarantee Issue

* Employee coverage is required in order to elect spouse and/or dependent coverage.

Exclusions, Limitations and Other Plan Information

GROUP WHOLE LIFE

EXCLUSIONS – No Benefits are provided for the following, nor will We pay any expenses incurred as a result of any Loss which is caused by, or sustained while, or incurred for, directly or indirectly: 1) suicide – If the Insured, whether sane or insane, dies by Suicide, within two (2) years* from the Effective Date, Our liability will be limited to an amount equal to the premiums paid for this Certificate.

* 1 year in CO, MO, ND.

OTHER LIMITATIONS AND EXCLUSIONS – The policy and riders have other elimination periods, exclusions and limitations that may affect coverage. Please refer to your certificate for full details.

DELAYED EFFECTIVE DATE PROVISION – Atlantic American Employee Benefits will postpone the Effective Date of an eligible Spouse/Dependent, other than a newborn child's coverage if, on that date, he or she is: 1) confined to a hospital or other health care facility; 2) home confined; or 3) unable to perform two or more daily living activities. In that case, we will postpone the Effective Date of his or her coverage until the day after the date: (a) of his or her discharge from such facility; (b) his or her home confinement ends; or (c) he or she is no longer requires assistance with two or more activities of daily living. If a Spouse/Dependent was covered under a prior plan at replacement, this language will not apply to the amount of coverage that was in force with the prior plan.

QUALIFYING CHRONIC ILLNESS – a Chronic Illness: 1) that was Diagnosed no more than twelve (12) months prior to the date We received a claim for benefits under this Rider; 2) that has continued while this Rider has been In Force for at least ninety (90) consecutive Days; 3) which was not caused by a mental or nervous disorder (except organically demonstrable disorders, such as Alzheimer's or senile dementia), alcoholism or drug addiction; and 4) which is expected to be Permanent.

PORTABILITY OPTION – If you, an employee, lose eligibility for this insurance, coverage can be continued by paying the premiums directly to us within 31 days after termination. We will bill the employee directly once we receive notification to continue coverage.

COVERED CHILDREN AND GRANDCHILDREN – Children are covered if the child is a natural, step, or legally adopted child and dependent of the employee. A grandchild is covered if the child is a dependent of the employee and filed as such on their federal tax returns. Children/grandchildren must reside in the U.S. to receive coverage.

CONVERSION – Within the 31-day period after the expiration date of the term insurance on each Dependent Child, such term insurance may be converted to a new whole life policy without evidence of insurability up to 5x the term rider coverage amount.

EXPIRATION OF CHILDREN TERM INSURANCE – The term insurance on each Dependent Child will expire on the earlier of 1) the end of the month of the child's 26th birthday; or 2) the date the Certificate matures or becomes paid up for its full Face Amount.

GROUP WHOLE LIFE INSURANCE



\$8,910

was the monthly median cost for a private room in a nursing home facility in 2021.

<https://bit.ly/3Fflouk>

chance that someone turning 65 will need long-term care services in their remaining years.

<https://bit.ly/3uTPdxs>

almost
70%

Group Whole Life policy form series B 21803 GMP, Accelerated Death Benefit Rider for Terminal Illness form B 21803 R1 ACL, Accelerated Death Benefit Rider for Chronic Illness form B 21803 R12 CIACL, Restoration of Benefits Rider for Chronic Illness form B 21803 R13 ROBCI, Extension of Benefits Rider form B 21803 R14 EOBR, Children's Term Insurance Rider form B 21803 R8 CTR, Waiver of Premium for Disability Rider form B 21803 R9 WPD, and Accidental Death and Dismemberment Rider form B 21803 R10 ADD underwritten by Bankers Fidelity Life Insurance Company®. Limitations and exclusions apply; the terms and conditions in the actual policy and certificate provisions control. Refer to the specific policy and certificate for details. Application to determine eligibility may be required. The Policy, any optional Riders and the benefits therein are subject to availability and may vary by state. This is only a summary of products and services offered; actual offerings may vary by group size and other underwriting or legal considerations. This is a solicitation of insurance and an independent agent may call on you.

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Group Customer Care

(866) 458-7502

groupcustomercare@atlam.com

aaemployeebenefits.com



Easy access to coverage

MyCoverage is an easy-to-use website that allows you to access coverage and benefit information 24/7, update your profile and more.
mycoverage.atlam.com



EMPLOYEE ASSISTANCE PLAN





YOUR MENTAL HEALTH MATTERS

The City of Fort Wayne understands the importance of mental health in your personal and professional life. As a thank you for your hard work and dedication, the City is enhancing your benefits package and increasing the number of counseling sessions available through the Parkview Employee Assistance Program. Effective June 1, 2023, you will have eight (8) sessions available per year.

Employee Assistance Program

Employee Assistance Program (EAP) counseling services are available to all City of Fort Wayne employees and those living in their household. All services are free for you to use and sessions are confidential and provided by a licensed Parkview counselor in a welcoming and comfortable setting. No information regarding participation in services is released to your employer without written consent from the patient.

Individuals and couples can meet with a counselor to discuss a variety of concerns, including (but not limited to):

- Crisis intervention
- Grief and loss
- Family and marital stress
- Relationship issues
- Alcohol and substance abuse
- Personal and work stress
- Divorce recovery
- Parent coaching
- Emotional difficulties
- Financial challenges

You are provided with eight (8) counseling sessions per person per calendar year for yourself and those living in your home.



Scan the QR code with your mobile phone camera for more information on Parkview EAP services and for a list of office locations.



Schedule an appointment with Parkview EAP: **260-266-8060** or **800-721-8809**

In-person and virtual appointment options are available.



If you or someone you know is currently experiencing thoughts of suicide, or a mental health or substance use crisis, please call **988** to reach the Suicide & Crisis Lifeline and speak with a trained crisis specialist 24/7.



PARKVIEW

EMPLOYEE ASSISTANCE PROGRAM



EMPLOYEE ASSISTANCE PROGRAM FAQ

No one is immune to hardship. That is why your employer is providing the Parkview Employee Assistance Program (EAP) for you and your family at no cost. This confidential service can be of great value as you work through life's storms. Below are frequently asked questions that will help guide you in understanding EAP.

What is an employee assistance program?

Parkview's EAP offers you, as well as those living in your household, short-term counseling services. Counseling sessions last between 45-50 minutes, are confidential, and are free of charge to you as an employee of your company. Your human resources department or manager can advise you as to the number of sessions provided by your company.

Will my co-workers, manager, or anyone else find out I came to see you?

Parkview's EAP services are confidential and no information about you, your participation in our program, or what you and your counselor talk about will be released to anyone without your written consent.

Please note: like any other counseling service you might receive, your counselor is legally required to report if you are intending to harm yourself, someone else, or in cases of child abuse or elder abuse.

What happens if I want to continue counseling after my sessions run out for the year?

The goal of EAP services is to help address your struggles, concerns, and stressors before they get to the point of needing long-term counseling. However, we understand that there will be situations when long-term counseling is needed. In these cases, your counselor will work with you to find options for an outpatient counselor within your insurance network who may be of assistance to you.

What if I am in a joint custody situation with my child and I want him/her to get counseling?

In cases regarding joint custody, we ask that both parents sign consent for the child to receive counseling services from Parkview EAP prior to the child being seen.

Can my family members receive counseling from Parkview's EAP?

Anyone living in your household, including spouses and children, are eligible to receive the same number of counseling sessions as you. For instance, if you receive four counseling sessions, your spouse receives four sessions as well.

How do I get started?

Give us a call at 260-266-8060 or 800-271-8809 to schedule an appointment with one of our counselors. Any family member who is seeking counseling who is 18 or older will need to call to make the appointment themselves.

To learn more about Parkview Employee Assistance Program and our counselors, visit Parkview.com/EmployerSolutions





Parkview Employee Assistance Program HELPING YOU WEATHER LIFE'S STORMS.

When facing life's storms, it's comforting to know that you have somewhere to turn.

An important resource

No one is immune to hardship. That is why your employer is providing the Parkview Employee Assistance Program (EAP) for you and your family at no cost. This confidential service can be of great value as you work through life's storms.

Private and professional

All of our EAP services are kept confidential. In fact, no information about you or your participation in the program is released without your written consent. Your participation in the EAP program will not be shared with your supervisor.

(continued)

Convenient locations

Visit Parkview.com/EmployerSolution for our most up-to-date list of locations.

Parkview Employee Assistance Program offering Zoom consultations

EAP provides consultations via your mobile device or a computer with a camera in the state of Indiana.



PARKVIEW

EMPLOYEE ASSISTANCE PROGRAM



Help in any situation

The Parkview Employee Assistance Program can help you and your family with a variety of difficult situations. The EAP counselors are knowledgeable in a variety of areas, including:

- Crisis intervention
- Trauma responses
- Family and relationship difficulties
- Alcohol and drug dependence
- Personal and work stress
- Divorce difficulties
- Troubled teenagers
- Emotional difficulties

Parkview EAP has an in-house financial counselor who can assist individuals with financial issues that are impacting their daily lives.

Often, the best approach includes short-term counseling sessions with an EAP professional. There may be times when a referral to another professional or agency better suited to address the situation is required.

Examples include:

- Support groups
- Outpatient counseling

Should the need arise, your insurance benefits and coverage would be considered.

Simple

When you or your family member calls for an appointment with an EAP counselor, your appointment will be scheduled as promptly as possible.

At the appointment, you will meet with a trained professional who will help assess your situation. He or she will assist you in determining the steps necessary for resolving the issue.

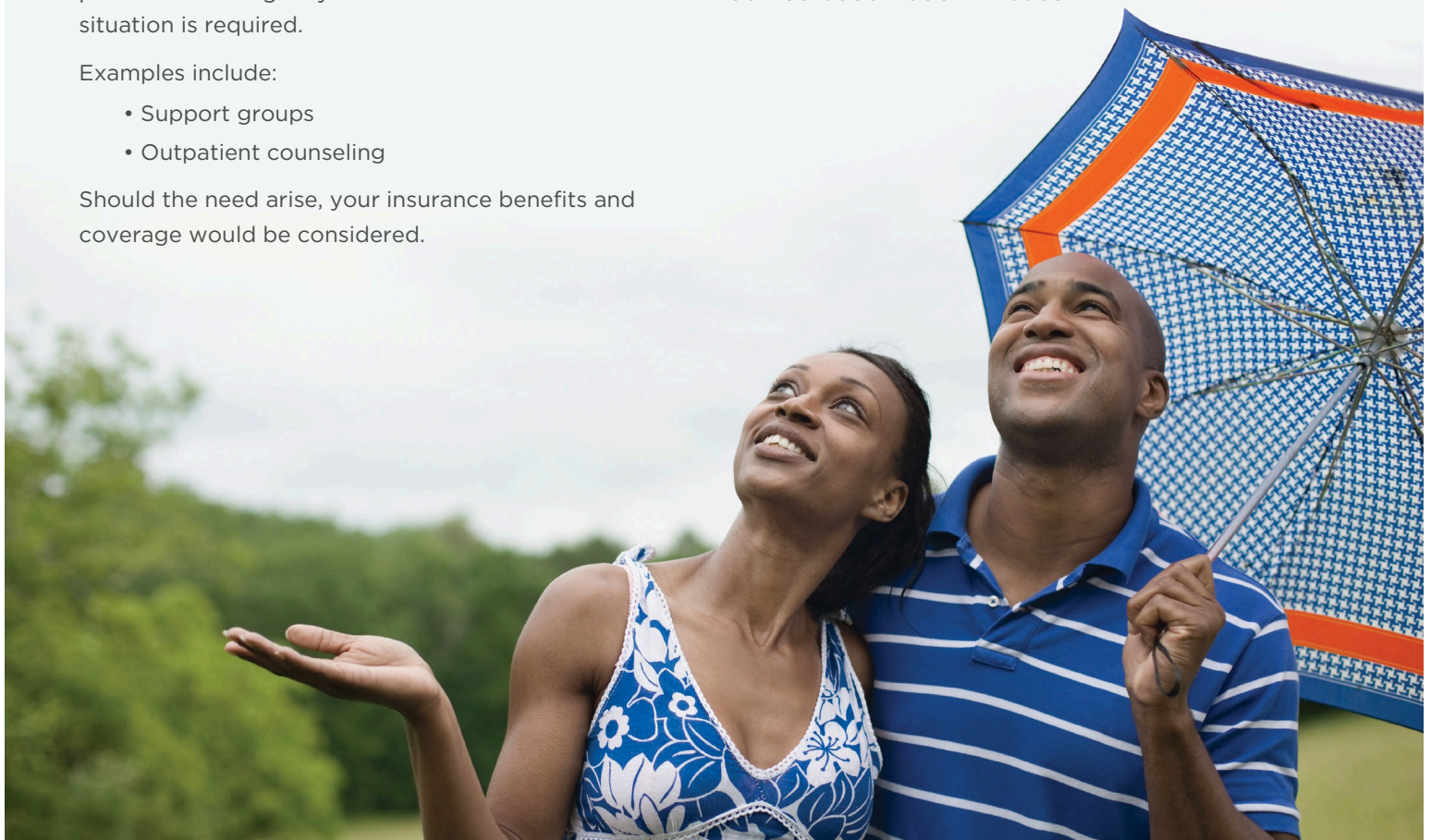
Your confidential EAP services are provided by your employer at no cost to you.

Flexible

The Parkview Employee Assistance Program counselors will make every effort to find an appointment that fits easily into your schedule. Confidential appointments can be made by you or any member of your family living in your home. Appointments for children under the age of 18 must be scheduled by a parent or guardian. Anyone over the age of 18 must schedule their own appointment.

**Call Parkview Employee Assistance Program today.
Together, we will ride out life's storms.**

260-266-8060 • 800-721-8809



Understanding your governmental 457(b) plan



SAVE TODAY FOR A MORE CONFIDENT TOMORROW

You recognize the importance of saving for your future. Enrolling in your retirement plan is a smart decision — and we're here to help you plan ahead, with information for every step along your journey to retirement.

Q&A: Know the basics

What's a 457(b) plan?

A 457(b) plan is a tax-deferred retirement plan designed to help you invest regularly for your retirement. Your contributions are taken directly from your salary before it's taxed and can be invested among a selection of investment options.

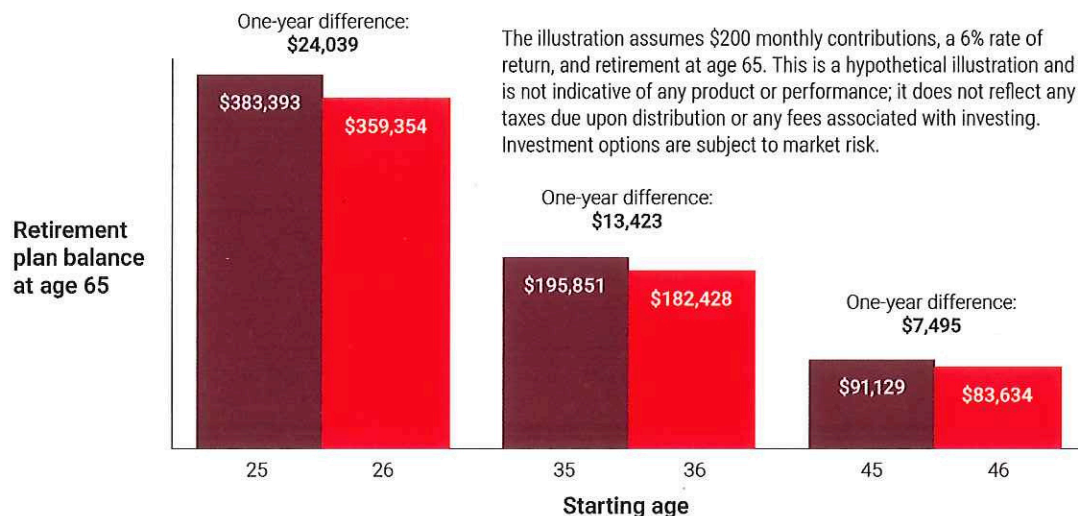
Why should I consider a 457(b) plan?

It's a great way to save for retirement:

- **It's easy!** You contribute through convenient automatic payroll deductions.
- **You get tax-deferred growth.** You don't pay taxes on your contributions and earnings until you withdraw them, which leaves more money in the plan to provide greater growth potential.
- **You'll be consistently saving.** Saving a set amount every payday can help you build the savings you need.

When should I start contributing to the plan?

Today! The earlier you start saving, the longer your money can grow. Beginning to save even one year earlier can make a difference.



Q&A: Making contributions

How do I make contributions?

It's simple. Once you're eligible, complete the necessary forms or enroll online, if that option is available. The amount you choose is withdrawn automatically from your paycheck and contributed to your retirement plan account. You can contribute to your 457(b) plan as long as you're an eligible employee, and you can change or discontinue your contributions, as allowed by your plan.



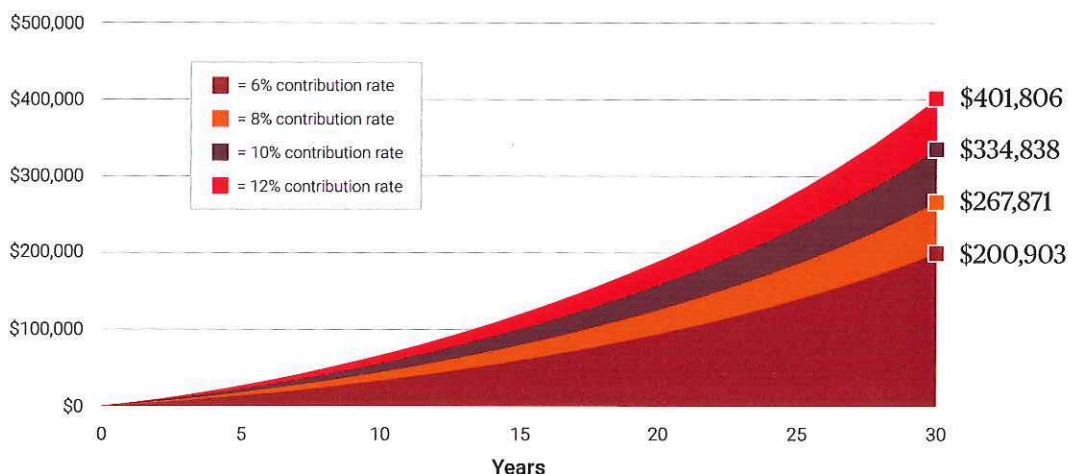
Saving just 2% more can help give your long-term savings a boost.

What if I can save only a small amount? Is it worth it?

Yes! Saving for retirement may be easier than you think. Commit just \$20 a week — what you might spend on coffee or soda — to your 457(b) plan, and see how even small contributions can add up over time. That \$20 each week may grow to \$40,176 in 20 years; \$87,418 in 30 years; or \$173,471 in 40 years.¹

How much should I contribute?

That depends on how much you can afford and how long you have until retirement. Even a small amount, invested regularly, can grow to significant savings. Challenge yourself to save an additional 2% each year — building up to a savings rate of 10% to 15% or more. These gradual steps can have a big impact over time.



These examples assume a \$40,000 annual salary and a 6% annual rate of return, compounded monthly, in a tax-deferred account. This is a hypothetical example. It is not indicative of any product or performance and does not reflect any expenses associated with investing. Distributions taken before age 59½ may be subject to an additional 10% federal tax. Taxes will be due upon distribution of the tax-deferred amount and, if shown, results will be lower. Actual investment results will fluctuate with the market so that, when you withdraw your investment, it may be worth more or less than the original amount invested.



Contributing the maximum every year can help you achieve your retirement goals.

Are there limits to the amount I can contribute?

Federal tax laws limit the total amount of annual elective deferrals that can be made to all employer-sponsored plans on your behalf, including pretax salary deferrals and employer contributions. Visit LincolnFinancial.com/Retirement or IRS.gov for the most current information.

If you join the plan midyear, you can make up for missed contributions through your current employer's payroll deduction. Your total contributions with your current and prior employers can't exceed the annual limit.

¹ This example assumes a 6% annual rate of return compounded weekly in a tax-deferred account. This is a hypothetical example. It is not indicative of any product or performance and does not reflect any expense associated with investing. Taxes will be due upon distribution of the tax-deferred amount and, if shown, results will be lower. It is possible to lose money by investing in securities.



Harness the power of tax deferral by saving in your 457(b) plan.

Q&A: Receiving tax benefits

Are there tax benefits to investing in my 457(b) plan?

Yes! Your contributions are deducted from your pay before taxes, which lowers your taxable income and gives you an immediate tax break.

Also, your contributions and earnings grow tax-deferred. That means you won't pay income taxes on your money until it's withdrawn. Please note that plan distributions are subject to normal income taxes.

Q&A: Accessing your account before retirement

Can I take a withdrawal from my 457(b) account before retirement?

Withdrawals can be made for specific reasons:

- Attainment of age 59½ while you're still employed (if allowed by your plan)
- Separation from service with your employer
- Distributions made to your beneficiaries upon your death
- Loans (if allowed by your plan)
- Qualified Domestic Relations Order (divorce payments to children or an ex-spouse)
- Unforeseeable emergency
- Birth or adoption of a child (if your plan allows; up to \$5,000 per child, penalty-free)

If you take a withdrawal and don't roll it into an eligible retirement plan, you'll pay income taxes on the distribution, which is generally subject to 20% federal withholding and will be taxed as ordinary income for the year it's withdrawn. In addition, the account may impose withdrawal or surrender charges. Some plans may have additional withdrawal limitations.

Can I take a loan?

Loans may be available, but it's important to consider the potential impact to your long-term savings before you borrow money from your retirement account.

What happens to my money if I change jobs?

You have several options:

- Leave your money in your previous employer's plan, if permitted.
- Move assets from your current plan to another eligible retirement plan offered by your new employer, if available, or to another qualified retirement account, such as an Individual Retirement Account (IRA), which may have different fees.
- Take a cash distribution. Be aware that a cash distribution is generally subject to 20% withholding and will be taxed as ordinary income for the year it's withdrawn.

What happens to my 457(b) account upon my death?

Your funds are passed to your designated beneficiary. To ensure that your assets are distributed as you desire, it's important to designate one or more beneficiaries and keep your beneficiary information up to date.



Before you take an early withdrawal, make sure you know the potential tax consequences.



Develop a retirement income strategy, including income from your retirement plan and your Social Security benefit.

Q&A: Reaching retirement

How can I receive my retirement distributions?

They may be paid via automatic withdrawal, an annuity, or a lump sum.

Once I retire, am I required to take regular distributions?

The federal tax code requires you to begin receiving distributions as of your required beginning date.² Once you begin receiving required minimum distributions, you must continue to receive them until your account value is depleted or until your death.

Will contributing to a 457(b) plan affect my Social Security benefits?

No. However, if you work for a government agency or other employer that doesn't withhold Social Security taxes from your salary, any pension you receive based on that employment may reduce your Social Security benefits.

² Your required beginning date (RBD) depends on when you were born. If you were born on or before June 30, 1949, your RBD is April 1 following the year you attained age 70½. If you were born after June 30, 1949, but before January 1, 1951, your RBD is April 1 following the year you attained age 72. If you were born in 1951 through 1959, your RBD is April 1 following the year you attained age 73. If you were born in 1960 or later, your RBD is April 1 following the year you attained age 75.



Contact your employer or your retirement plan representative for more information.

Stay current and register your online account at LincolnFinancial.com/Register.

Not a deposit
Not FDIC-insured
Not insured by any federal government agency
Not guaranteed by any bank or savings association
May go down in value

Mutual funds and variable annuities are sold by prospectus. Investors are advised to consider carefully the investment objectives, risks, and charges and expenses of a mutual fund and, in the case of a variable annuity, the variable contract and its underlying investment options. To obtain a mutual fund or variable annuity prospectus that contains this and other information, call 800-4LINCOLN. Carefully read the prospectus before investing or sending money.

Variable annuities are long-term investment products designed particularly for retirement purposes and are subject to market fluctuation, investment risk and possible loss of principal. Variable annuities contain both investment and insurance components and have fees and charges, including mortality and expense, administrative and advisory fees. Optional features are available for an additional charge. The annuity's value fluctuates with the market value of the underlying investment options, and all assets accumulate tax-deferred. Withdrawals of earnings are taxable as ordinary income and, if taken prior to age 59½, may be subject to an additional 10% federal tax. Withdrawals will reduce the death benefit and cash surrender value. There is no additional tax-deferral benefit for an annuity contract purchased in an IRA or other tax-qualified plan.

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PAD-5506078-031023

POD ADA 4/23 Z05

Order code: DC-457-FLI002





**Take control of
your financial
future today**



Nationwide®

An opportunity to maximize your retirement future

If you plan to rely solely on your pension and Social Security benefits for income, you could face a potential gap in your budget.

Your income gap could be nearly 40% at retirement. Here's why:

70% to 90%

Amount of your income at retirement that experts say you may need to maintain your standard of living in retirement¹

51%

Amount of current income a public pension may provide²

59

Age at which most public employees retire³; first responders tend to retire around age 55, well before the age to qualify for Social Security benefits⁴

Potentially making that gap even larger are other factors such as:

- Out-of-pocket medical costs
- Inflation
- Not qualifying for full benefits
- Outliving your resources
- Needing long-term care
- Planning for major trips and other activities

Why you should participate in your 457(b) plan:

• Flexible

Change your investment mix or contribution amount at any time.

• Automatic

Earnings are reinvested, harnessing the power of compounding.

• Accessible

You can withdraw 457(b) assets without penalty when you leave service or retire, regardless of your age.

• Easy

Payroll deduction means your contributions are automatic.

• Low-cost

Through group buying, we negotiate lower fund fees than individuals may be able to get on their own.

• Tax advantaged

Tax-deferred contributions give your account a chance to grow more quickly.⁵

Roth after-tax contributions allow you to plan for tax-free retirement income.⁶

• Portable

If you leave your job, you may be able to roll your assets into another eligible retirement plan or IRA.

Why join now?

These creeping red giant of long-term savings is time.

The more time you give your savings to potentially grow, the easier it is to contribute enough per pay period to potentially meet your future needs.

How much should you save?

While this decision is unique to each employee, we offer two online tools that can help you decide:

Paycheck Impact Calculator



See how your take-home pay would be affected by various contribution amounts.

My Investment PlannerSM



Identify your investment style based on a number of factors, including target retirement date, retirement goals and tolerance for risk.

How do you want to handle investment decisions?

Option 1: Do it myself

Investigate the Plan's investment options and fees, then pick the right mix for your investment strategy.

Option 2: Help me do it

Use **My Investment Planner** SM to find options that might fit your investing style and tolerance for risk.

Option 3: Do it for me

Enroll in **Nationwide ProAccount**[®], the Plan's available for an additional fee. professional account management program,

We make getting started easy!

Gather these items:

- **Social Security number**
- **Annual salary**
- **Employer ID:**
- **Employer Name: City of Fort Wayne**



To schedule an individual appointment, scan this code.

For personal assistance, contact Patrick Burkhart



Patrick Burkhart
260-385-6336
p.burkhart@nationwide.com



¹ "Taking the Mystery out of Retirement Planning," U.S. Department of Labor, Employee Benefits Security Administration (November 2020).

² "Net Pension Replacement Rates," Organization for Economic Cooperation and Development (2021).

³ "Public pension eligibility," Ballotpedia (accessed Oct. 11, 2021).

⁴ "Retirement Planning Needs of Private- and Public-Sector Employees More Similar Than Different," PlanSponsor (Oct. 27, 2020).

⁵ Under current tax law, you would pay ordinary income taxes when you take withdrawals.

⁶ Withdrawals would be tax free as long as you're at least 59½ and do not take withdrawals from your designated Roth account for at least 5 years after your first contribution is made to your Plan.

This material is not a recommendation to buy or sell a financial product or to adopt an investment strategy. Investors should discuss their specific situation with their financial professional.

No investment strategy or program, including participation in Nationwide ProAccount, can guarantee to make a profit or avoid loss.

Nationwide Investment Advisors LLC (NIA) provides investment advice to plan participants enrolled in Nationwide ProAccount. NIA is an SEC-registered investment adviser.

NIA has retained Wilshire® as an Independent Financial Expert for Nationwide ProAccount. Wilshire provides investment allocation portfolios based on participant ages and their personal tolerance for investment risk.

NIA assesses participants an asset-based fee for the managed account services.

Retirement products are offered by Nationwide Trust Company, FSB, or Nationwide Life Insurance Company.

Wilshire is a registered service mark of Wilshire Associates, which is not an affiliate of Nationwide or NIA.

Investing involves market risk, including possible loss of principal.

Nationwide, the Nationwide N and Eagle, Nationwide ProAccount and My Investment Planner are service marks of Nationwide Mutual Insurance Company.

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NRM-19251M1.4 (02/24)



PERF HYBRID AT A GLANCE

PUBLIC EMPLOYEES' RETIREMENT FUND HYBRID PLAN

Defined Benefit

Defined Contribution (DC) Account

Vesting

10 years of PERF and/or TRF-covered service
8 years for specified elected positions

Immediate

Contributions

- The employer pays 100%.
- The INPRS Board of Trustees determines the employer contribution rate annually.
- No member contributions.

Mandatory 3% of gross wages paid by:

- Employer, or
- Employee, or
- Shared by both employee and employer.

Voluntary Contributions¹

The employee can elect to make additional post-tax contributions.

Investment Options

Members do not direct the investment of the Defined Benefit.

Member can choose from 8 funds:

- Stable Value Fund
- Money Market Fund
- Fixed Income Fund
- Inflation-Linked Fixed Income Fund
- Large Cap Equity Index Fund
- Small/Mid Cap Equity Fund
- International Equity Fund
- Target Date Funds

Eligibility for Retirement Benefit

- Age 65 with 10 years of service.
- Age 60 with 15 years of service.
- At age 55 if age and creditable service total at least 85 ("Rule of 85").
- Early retirement with reduced benefits between ages 50-59 with 15 years of service.
- Age 65 with 20 years of service.²
- Special provisions for certain elected officials.

Automatic eligibility to withdraw DC balance once member separates from service.³

Members separated from service may retire with the PERF Hybrid Plan and continue to work in a non-INPRS covered position if they meet age and service requirements.

Eligibility for Disability Benefit

- Qualified for Social Security disability benefits and provided proof of qualification.
- Received a salary from a PERF-covered position within 30 days of the termination date.
- Minimum of 5 years of service.

Automatic eligibility to withdraw DC balance if receiving a disability benefit.

Account Statements

Members receive PERF Annual Member Statements (AMS) by mail. The AMS includes an estimated annual defined benefit amount, years of service, and DC account investment information. Members can choose to have the AMS sent via email every year. Copies are also available from the member's online account at myINPRSretirement.org.

Quarterly member statements are provided online and/or mailed by INPRS.

¹Go to the PERF Hybrid Member Handbook for more on voluntary contributions.

²Actively employed members who have completed at least 20 years of service may apply for retirement benefits at age 65, remain actively employed, and receive monthly benefits.

³Certain restrictions may apply if the member is vested in a pension benefit.

PERF HYBRID AT A GLANCE

Defined Benefit

Defined Contribution (DC) Account

Withdrawals

None – members are not eligible for the Defined Benefit until they reach age and service requirements and separate from employment.

Members who are NOT separated from service may take a DC withdrawal if:

- the member is at least age 59½ AND age & service eligible for full retirement benefits; or the member is working in non PERF Hybrid position, is at least age 59½, AND age & service eligible for full retirement benefits.

Members who are disabled or separated from service:

- may leave the DC account invested in INPRS or receive a distribution, or
- may roll over the DC account to a qualified plan or other eligible retirement accounts.

Income and Options at Retirement

The monthly lifetime benefit amount is determined by:

- Age
- Years of service
- Average annual compensation (Final Average Salary) based on 20 quarters
- Multiplier of 1.1 percent (.011)
 - Benefit amount is taxable as ordinary income
 - Survivor options are available

The monthly benefit amount is affected by the payment option election made at retirement.

Any Cost of Living Adjustment (COLA) must first be approved by the Indiana General Assembly.

Member chooses the form of payment.

- May choose monthly payment for the lifetime benefit
 - May defer payment until RMD (required minimum distribution) age
- May choose direct payment or rollover distribution

The amount of distribution is determined by account balance, taxes withheld, and distribution option chosen.

Beneficiaries

Monthly payment

- Following the death of a retired member under applicable payment options.
- Following the death of an active member based on eligibility.

Balance payment

- Receives the total accumulated amount after the death of an active member or retired member who elected to defer payment.
- Receives remainder of the accumulated amount per retirement payment options chosen by the member.

FOR YOUR BENEFIT

This handout is an overview of the PERF Hybrid plan provisions. Complete details are available in the PERF Hybrid plan member handbook. You may read it or print your copy from the INPRS website. You may also request a copy in writing or by calling our toll-free number, (844) GO-INPRS or 844-464-6777.

Keep your name, address, and beneficiary choices current. Visit your online account at myINPRSretirement.org to make changes. Without a current address, INPRS can't reach you when you may be retirement eligible. INPRS can pay 6 months of retroactive pension benefits only. INPRS can pay death benefits to designated beneficiaries on file. Don't let death benefits go to the wrong person.

Every attempt has been made to verify that the information in this publication is correct and up-to-date. Published content does not constitute legal advice. If a conflict arises between the information contained in this publication and the law, the applicable law shall apply.

Notices



Newborn's and Mother's Health Protection Act

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

Women's Health and Cancer Rights Act

Group health plan expenses for a mastectomy shall also include charges for the reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications in relation to all stages of the mastectomy, including lymphedemas. Coverage shall be provided in a manner determined in consultation with the attending physician and the patient.

Michelle's Law

Michelle's Law allows seriously ill college students, who are covered dependents under health plans, to continue coverage for up to one year while on medically necessary leaves of absence. The leave must be medically necessary as certified by a physician, and the change in enrollment must commence while the dependent is suffering from a serious illness or injury and must cause the dependent to lose student status. Under the law, a dependent child is entitled to the same level of benefits during a medically necessary leave of absence as the child had before taking the leave. Further, if any changes are made to the health plan during the leave, the child remains eligible for the changed coverage in the same manner as would have applied if the changed coverage had been the previous coverage, so long as the changed coverage remains available to other dependent children under the plan.

Your Enrollment Rights

If you enroll in your employer plan or waive coverage, you have special enrollment rights for situations which might come up in the future. For example: loss of other health insurance coverage (either through a spouse, parent or Medicaid), marriage, divorce, birth or adoption of child. If you experience any of these situations, you need to notify your HR department so that you and your dependents may enroll in the employer plan as of the date of the change. The insurance company needs to receive an updated enrollment form within 30 days of the special enrollment situation.

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 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).

Grandfathered Notice

City of Fort Wayne believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your Human Resources Department. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Medicare Part D

Important Notice from the City of Fort Wayne (we or us) About Your Prescription Drug Coverage under the City of Fort Wayne Employee Benefit Plan (our plan) and Medicare Part D Prescription Drug Coverage.

Important: This Notice applies to you only if you are a Part D eligible individual. A Part D eligible individual is someone who has coverage under Medicare Part A or Part B which may include active employees, disabled employees, COBRA participants, retirees, and their covered spouses and dependents. If you do not currently have Medicare Part A or Part B and have not recently applied for Medicare Part A or Part B, then this Notice does not apply to you.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with us and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

Notices



1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. It has been determined that the prescription drug coverage offered by the City of Fort Wayne Employee Benefit Plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you do decide to join a Medicare drug plan, your current City of Fort Wayne will not be affected.

1. You can keep your prescription drug coverage through City of Fort Wayne and elect Medicare drug coverage at a later time. Because your prescription drug coverage is at least as good as standard Medicare drug coverage, you will not pay a higher premium for Medicare drug coverage if you decide to join later.

2. You can keep your health coverage through City of Fort Wayne and join a Medicare drug plan. Because your prescription drug coverage is at least as good as standard Medicare drug coverage and your prescription drug coverage through City of Fort Wayne would be the primary plan, unless your coverage is through COBRA, you may not need to join a Medicare drug plan.

3. Your health plan with City of Fort Wayne pays for other expenses in addition to prescription drugs, so you cannot drop just prescription drug coverage. **If you decide to drop all health coverage through City of Fort Wayne and join a Medicare drug plan, you may re-enroll in the Plan during our annual open enrollment.**

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

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

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

For more information about this notice or your current prescription drug coverage...

Contact our office for further information. NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through our plan changes. You also may request a copy of this notice at any time.

For more information about Medicare prescription drug coverage...

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

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

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

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

Date: September 26, 2025
Name of Entity/Sender: City of Fort Wayne
Contact--Position/Office: HR/Benefits Manager
Address: 200 East Berry St, Suite 370, Fort Wayne, IN 46802
Phone Number: 260-427-2634



CITY OF FORT WAYNE PLAN COBRA NOTIFICATION

Consolidated Omnibus Budget Reconciliation Act



VERY IMPORTANT NOTICE! Please share this information with your spouse and dependents.

To provide options for individuals who lose health coverage from an employer-sponsored insurance plan, the Federal Government enacted the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272, Title X), commonly known as "COBRA."

COBRA LAW With the exception of church groups and the Federal Government, employers with twenty (20) or more employees (number of employees may vary by state) that provide health benefits are subject to offering employees (and/or their covered dependents) the right to a temporary extension of group insurance (called "continuation coverage") upon experiencing a "qualifying event." We request that you (and your covered dependents) take the time to read this important notification.

This procedure is different from converting to individual coverage after termination of employment. The major advantages are that participants cannot be discriminated against for having a pre-existing medical condition and will be charged the company's group rate (plus a two percent administrative fee). These COBRA rates may (or may not) be less than premiums under a conversion so it is recommended that you contact the insurer to receive a quote. With many conversion plans, covered benefits are reduced. Under COBRA continuation, your benefits would remain identical to the group plan's coverage. COBRA also allows for covered dependents to independently continue their health coverage when lost through a "qualifying event."

EMPLOYER AND QUALIFIER'S RESPONSIBILITIES When an employee or dependent has experienced a "qualifying event," they will be sent notification of their rights to elect COBRA continuation coverage. Employers shall provide this notification within fourteen (14) days from the date group coverage would be terminated (or as soon as administratively possible). The employee or dependent has the responsibility to notify our office of their desire to continue coverage within sixty (60) days from the later of the date of notification or loss of coverage. Upon acceptance, the qualifier(s) would be notified of any enrollment forms that must be completed. Keep in mind, qualifier(s) electing continuation coverage are responsible for premiums back to the date termination from the plan would have occurred.

PARTICIPANT NOTIFICATION REQUIREMENT The City of Fort Wayne will not know when certain "qualifying events" occur. The Employee or Covered Dependent will be responsible for notifying our office of a Divorce, Legal Separation or when a dependent loses his/her "dependent status." The employee or affected dependent has sixty days (election period) to notify our office of the "qualifying event" and their desire to continue coverage. If we are not notified within this time frame, COBRA continuation cannot be offered.

The employee (and/or dependent) will not have coverage during the sixty day election period. Only if he/she elects to continue coverage and pays the applicable premiums will benefits be paid during this time frame.

COBRA QUALIFYING EVENTS Listed below are "qualifying events" for which the employee and/or covered dependents are able to continue their health coverage under the COBRA legislation. As shown, the maximum continuation coverage time frame depends on the "qualifying event" experienced. For someone to be considered a "qualified beneficiary," they must have been enrolled on the group plan on the day prior to the "qualifying event." One exception to this rule is when a child is born to (or placed for adoption with) an employee during the COBRA continuation period. These children will receive all rights of a "qualified beneficiary" throughout the COBRA continuation period. In the past, employers did not have to offer COBRA continuation to qualifiers that had alternative coverage (Medicare or other group insurance). A recent Supreme Court ruling stated that COBRA must be offered to qualifiers even if they have other coverage at the time of the "qualifying event."

Qualifying Events That Yield a Maximum of 18 Months (Experienced by the Employee)

1. Termination of employment (for reasons other than "gross misconduct");
2. Reduction of Employee's Work Hours

Qualifying Events that Yield a Maximum of 36 Months (Experienced by a Covered Dependent)

1. Death of the Employee;
2. Divorce or Legal Separation
3. Employee qualifies for Medicare but dependents do not;
4. Dependent Child who no longer meets the insurer's definition of a "dependent".

BECOMING DISABLED - In the event of an employee's termination or reduction in work hours, employees or covered dependents who become classified as "disabled" by Social Security (under Title 11 or Title XVI) within the first sixty days of COBRA continuation are eligible for an additional 11 months of coverage (yielding a total of 29 months). For this extension to apply, evidence of disability under the Social Security Act must be provided to the employer within the initial 18 month continuation coverage time frame and within 60 days from the date of the Social Security Administration's determination.





FAMILY AND MEDICAL LEAVE ACT Effective August 5, 1993, the Family and Medical Leave Act of 1993 (FMLA) was enacted to allow eligible employees the right to take up to 12 weeks of unpaid leave to care for themselves or a relative. If you elect to take this leave and later notify the company that you will not be returning, you have the ability to continue your coverage for 18 months from the date benefits are terminated.

MULTIPLE QUALIFYING EVENTS If an employee experiences termination, reduced work hours or is considered "disabled," elects to continue coverage and a covered dependent experiences a second "qualifying event," the dependent may increase their maximum time frame under COBRA from 18 (or 29 for a disability) to 36 months. The maximum continuation period for any qualifying event is thirty-six (36) months. As stated earlier, it is the responsibility of the employee or covered dependent to notify our office within 60 days of the second "qualifying event."

COBRA TERMINATION COBRA continuation coverage has maximum time frames but you may voluntarily terminate coverage at anytime by notifying our office in advance. The COBRA legislation provides the employer the right to terminate continuation coverage for one or more of the following reasons:

1. The company terminates the plan(s) (you are continuing) for all active employees;
2. The COBRA premiums are not paid in a timely manner;
3. If the employee and/or covered dependents become covered under another group plan. (However, if the new plan excludes a covered person's medical pre-existing condition, that person may continue under the COBRA continuation coverage. The Health Insurance Portability and Accountability Act of 1996 limits maximum time frames for pre-existing conditions, therefore a person with prior creditable coverage exceeding the pre-existing limitation period of the new group plan may be terminated by the employer); or
4. An employee becomes entitled to Medicare. (Dependent's continuation coverage may be extended to 36 months upon notifying our office of the employee's Medicare entitlement.)

PREMIUM COSTS The cost of continuation coverage will be determined at the time of the "qualifying event." Your cost will be the amount the insurance company charges the City of Fort Wayne for active employees (with similar coverage type) plus a 2% administration fee. If the insurer delivers a premium increase or reduction, the COBRA participant's premiums will be adjusted accordingly.

CONVERSION TO AN INDIVIDUAL PLAN A conversion plan allows individuals covered under a group plan to convert their coverage to an individual plan without a lapse in coverage or pre-existing condition limitations upon termination from the group plan. Not all group plans are subject to offering a conversion. If you are enrolled in a plan that allows conversions, our firm will send notification explaining conversion privileges in the last 180 days of your COBRA term.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 With the signing of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), COBRA's rules changed creating further options to individuals losing insurance coverage under a group plan. The law further defined the "Disability Extension," Eligible COBRA Qualifying Beneficiaries and when a coverage can be terminated from COBRA due to new coverage under another group plan.

The scope of the law is to eliminate barriers for individuals (mainly people with medical pre-existing conditions that would have difficulty obtaining immediate coverage) who lose coverage and want to find some form of replacement plan. Effective dates for most of the provisions will vary depending on the contract renewal date of group plans but all employers should be responsible for the law by June 30, 1998.

The law limits a plan's "pre-existing condition limitation time frame" to twelve (12) months for newly enrolling individuals and provides credit for prior coverage. A Certificate of Coverage will be provided when you terminate from a group plan that illustrates coverage under that program. This certificate should be shown to a new employer to receive the one month credit for every month of prior coverage. Keep in mind, that if there is a break in coverage greater than sixty-three (63) days, the new employer does not have to provide any prior coverage credit. In addition, if you elect COBRA and exhaust either the eighteen (18) or thirty-six (36) months maximum time frame, you may be eligible for coverage under an individual plan (through an insurer of your choice) on a guaranteed issue basis without any pre-existing condition limitations.

Lastly, HIPAA allows individuals to pay for their COBRA premiums from withdrawals from an Individual Retirement Account (IRA). After December 31, 1996, withdrawals may be made penalty free (usually 10%) for medical insurance if the individual has received unemployment compensation under federal or state law for at least twelve (12) weeks. This provision only eliminates the 10% penalty fee and not the standard income tax.

INSURANCE PLAN REQUIREMENTS Some group insurance plans require members to receive services from contracted providers. If you elect COBRA continuation coverage and move from the insurer's "service area," your coverage cannot be continued under the group plan.

ACCEPTANCE PROCEDURES Upon receiving the COBRA Qualifying Event notification, the qualifier will be responsible for completing the appropriate forms and returning them to the administrator prior to the end of the sixty day election period. Even though there is a forty-five day grace period, we recommend that all premiums (back to the date coverage was terminated) be paid with the submission of the COBRA applications. From that point on, it is the qualifier/COBRA participant's responsibility to make premium payments in a timely fashion. COBRA premiums shall be prepaid and due on the first of the month. The law provides a thirty-one day grace period for all premium payments after the initial payment. If payment is not received within this time frame, COBRA coverage will be terminated.

QUESTIONS REGARDING COBRA If you have any questions regarding this notification of your COBRA rights, please feel free to contact The Benefits & Wellness Department during working hours.



EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.



For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV





***CITY OF FORT WAYNE
NOTICE OF PRIVACY PRACTICES***

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

This Notice of Privacy Practices describes how protected health information (or “PHI”) may be used or disclosed by City of Fort Wayne Group Health Plan (we/us) to carry out payment, health care operations, and for other purposes that are permitted or required by law. This Notice also sets out our legal obligations concerning your PHI, and describes your rights to access, amend and manage your PHI.

PHI is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer (when functioning on behalf of the group health plan), or a health care clearing-house and that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you. This Notice of Privacy Practices had been drafted to be consistent with what is known as the “HIPAA Privacy Rule,” and any of the terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Rule.

If you have any questions or want additional information about the Notice or the policies and procedures described in the Notice, please contact:

Title: ____ Benefits Manager ____

Name: ____ Laura Helmkamp ____

Address: ____ 200 E. Berry, Suite 370, Fort Wayne, IN 46802 ____

Telephone Number: ____ (260) 427-2634 ____

EFFECTIVE DATE

This Notice of Privacy Practices becomes effective on ____ September 23, 2013 ____.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy of your PHI. We are obligated to: provide you with a copy of this Notice of our legal duties and of our privacy practices related to your PHI; abide by the terms of the Notice that is currently in effect; and notify you in the event of a breach of your unsecured PHI. We reserve the right to change the provisions of our Notice and make the new provisions effective for all PHI that we maintain. If we make a material change to our Notice, we will make the revised Notice available upon request. **[This Notice is on our Website and is available electronically].**





Permissible Uses and Disclosures of PHI

The following is a description of how we are most likely to use and/or disclose your PHI.

- ***Payment and Health Care Operations.*** We have the right to use and disclose your PHI for all activities that are included within the definitions of “payment” and “health care operations” as set out in 45 C.F.R. § 164.501 (this provision is a part of the HIPAA Privacy Rule). We have not listed in this Notice all of the activities included within these definitions, so please refer to 45 C.F.R. § 164.501 for a complete list.

- **Payment**

We will use or disclose your PHI to pay claims for services provided to you and to obtain stop-loss reimbursements or to otherwise fulfill our responsibilities for coverage and providing benefits. For example, we may disclose your PHI when a provider requests information regarding your eligibility for coverage under our health plan, or we may use your information to determine if a treatment that you received was medically necessary.

- **Health Care Operations**

We will use or disclose your PHI to support our business functions. These functions include, but are not limited to: quality assessment and improvement, reviewing provider performance, licensing, stop-loss underwriting, business planning, and business development. For example, we may use or disclose your PHI: (i) to provide you with information about a disease management program; (ii) to respond to a customer service inquiry from you; or (iii) in connection with fraud and abuse detection and compliance programs.

Other Permissible Uses and Disclosures of PHI

The following is a description of other possible ways in which we may (and are permitted to) use and/or disclose your PHI.

- ***Required by Law.*** We may use or disclose your PHI to the extent the law requires the use or disclosure. When used in this Notice, “required by law” is defined as it is in the HIPAA Privacy Rule. For example, we may disclose your PHI when required by national security laws or public health disclosure laws.
- ***Public Health Activities.*** We may use or disclose your PHI for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or we may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. We also may disclose PHI, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.
- ***Health Oversight Activities.*** We may disclose your PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.





- ☐ ***Abuse or Neglect.*** We may disclose your PHI to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, we may disclose to a governmental entity authorized to receive such information your PHI if we believe that you have been a victim of abuse, neglect, or domestic violence.
- ☐ ***Legal Proceedings.*** We may disclose your PHI: (i) in the course of any judicial or administrative proceeding; (ii) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (iii) in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your PHI in response to a subpoena for such information, but only after we first meet certain conditions required by the HIPAA Privacy Rule.
- ☐ ***Law Enforcement.*** Under certain conditions, we also may disclose your PHI to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (i) it is required by law or some other legal process; (ii) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person; and (iii) it is necessary to provide evidence of a crime that occurred on our premises.
- ☐ ***Coroners, Medical Examiners, Funeral Directors; Organ Donation Organizations.*** We may disclose PHI to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose PHI to organizations that handle organ, eye, or tissue donation and transplantation.
- ☐ ***Research.*** We may disclose your PHI to researchers when an institutional review board or privacy board has: (i) reviewed the research proposal and established protocols to ensure the privacy of the information; and (ii) approved the research.
- ☐ ***To Prevent a Serious Threat to Health or Safety.*** Consistent with applicable federal and state laws, we may disclose your PHI if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We also may disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.
- ☐ ***Military Activity and National Security, Protective Services.*** Under certain conditions, we may disclose your PHI if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose your PHI to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.
- ☐ ***Inmates.*** If you are an inmate of a correctional institution, we may disclose your PHI to the correctional institution or to a law enforcement official for: (i) the institution to provide health care to you; (ii) your health and safety and the health and safety of others; or (iii) the safety and security of the correctional institution.
- ☐ ***Workers' Compensation.*** We may disclose your PHI to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.
- ☐ ***Emergency Situations.*** We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previously identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interests. If the disclosure is in your best interest, we will disclose only the PHI that is directly relevant to the person's involvement in your care.





- ☐ **Fundraising Activities.** We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance its activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.
- ☐ **Group Health Plan Disclosures.** We may disclose your PHI to a sponsor of the group health plan – such as an employer or other entity – that is providing a health care program to you. We can disclose your PHI to that entity if that entity has contracted with us to administer your health care program on its behalf.
- ☐ **Underwriting Purposes.** We may use or disclose your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing in the underwriting process your PHI that is genetic information.
- ☐ **Others Involved in Your Health Care.** Using our best judgment, we may make your PHI known to a family member, other relative, close personal friend or other personal representative that you identify. Such a use will be based on how involved the person is in your care, or payment that relates to your care. We may release information to parents or guardians, if allowed by law. If you are not present or able to agree to these disclosures of your PHI, then, using our professional judgment, we may determine whether the disclosure is in your best interest.

Uses and Disclosures of Your PHI that Require Your Authorization

Sale of PHI

We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.

Marketing

We will request your written authorization to use or disclose your PHI for marketing purposes with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.

Psychotherapy Notes

We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or health care operation functions.

Other uses and disclosures of your PHI that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

Required Disclosures of Your PHI

The following is a description of disclosures that we are required by law to make.

- ☐ **Disclosures to the Secretary of the U.S. Department of Health and Human Services.** We are required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.





- **Disclosures to You** We are required to disclose to you most of your PHI in a “designated record set” when you request access to this information. Generally, a “designated record set” contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. We also are required to provide, upon your request, an accounting of most disclosures of your PHI that are for reasons other than payment and health care operations and are not disclosed through a signed authorization.

We will disclose your PHI to an individual who has been designated by you as your personal representative and who has qualified for such designation in accordance with relevant state law. However, before we will disclose PHI to such a person, you must submit a written notice of his/her designation, along with the documentation that supports his/her qualification (such as a power of attorney).

Even if you designate a personal representative, the HIPAA Privacy Rule permits us to elect not to treat the person as your personal representative if we have a reasonable belief that: (i) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; (ii) treating such person as your personal representative could endanger you; or (iii) we determine, in the exercise of our professional judgment, that it is not in your best interest to treat the person as your personal representative.

- **Business Associates.** We contract with individuals and entities (Business Associates) to perform various functions on our behalf or to provide certain types of services. To perform these functions or to provide the services, our Business Associates will receive, create, maintain, use, or disclose PHI, but only after we require the Business Associates to agree in writing to contract terms designed to appropriately safeguard your information. For example, we may disclose your PHI to a Business Associate to administer claims or to provide member service support, utilization management, subrogation, or pharmacy benefit management. Examples of our business associates would be our Third Party Administrator, which will be handling many of the functions in connection with the operation of our Group Health Plan; the retail pharmacy; and the mail order pharmacy.
- **Other Covered Entities.** We may use or disclose your PHI to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with payment activities and certain health care operations. For example, we may disclose your PHI to a health care provider when needed by the provider to render treatment to you, and we may disclose PHI to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing. This also means that we may disclose or share your PHI with other insurance carriers in order to coordinate benefits, if you or your family members have coverage through another carrier.
- **Plan Sponsor.** We may disclose your PHI to the plan sponsor of the Group Health Plan for purposes of plan administration or pursuant to an authorization request signed by you.

Potential Impact of State Law

The HIPAA Privacy Rule regulations generally do not “preempt” (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.





YOUR RIGHTS

The following is a description of your rights with respect to your PHI.

- **Right to Request a Restriction.** You have the right to request a restriction on the PHI we use or disclose about you for payment or health care operations. ***We are not required to agree to any restriction that you may request.*** If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you. You may request a restriction by contacting the designated contact listed on the first page of this Notice. It is important that you direct your request for restriction to the designated contact so that we can begin to process your request. Requests sent to persons or offices other than the designated contact might delay processing the request.

We will want to receive this information in writing and will instruct you where to send your request when you call. In your request, please tell us: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

- **Right to Request Confidential Communications.** If you believe that a disclosure of all or part of your PHI may endanger you, you may request that we communicate with you regarding your information in an alternative manner or at an alternative location. For example, you may ask that we only contact you at your work address or via your work e-mail.

You may request a restriction by contacting the designated contact listed on the first page of this Notice. It is important that you direct your request for confidential communications to the designated contact so that we can begin to process your request. Requests sent to persons or offices other than the one indicated might delay processing the request.

We will want to receive this information in writing and will instruct you where to send your written request when you call. In your request, please tell us: (1) that you want us to communicate your PHI with you in an alternative manner or at an alternative location; and (2) that the disclosure of all or part of the PHI in a manner inconsistent with your instructions would put you in danger.

We will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of your PHI could endanger you. As permitted by the HIPAA Privacy Rule, "reasonableness" will (and is permitted to) include, when appropriate, making alternate arrangements regarding payment.

Accordingly, as a condition of granting your request, you will be required to provide us information concerning how payment will be handled. For example, if you submit a claim for payment, state or federal law (or our own contractual obligations) may require that we disclose certain financial claim information to the plan participant (*e.g.*, an Explanation of Benefits, or "EOB"). ***Unless*** you have made other payment arrangements, the EOB (in which your PHI might be included) will be released to the plan participant.

Once we receive all of the information for such a request (along with the instructions for handling future communications), the request will be processed usually within three business days.

Prior to receiving the information necessary for this request, or during the time it takes to process it, PHI might be disclosed (such as through an EOB). Therefore, it is extremely important that you contact the designated contact listed on the first page of this Notice ***as soon as*** you determine that you need to restrict disclosures of your PHI.





If you terminate your request for confidential communications, the restriction will be removed for **all** your PHI that we hold, including PHI that was previously protected. Therefore, you should not terminate a request for confidential communications if you remain concerned that disclosure of your PHI will endanger you.

- **Right to Inspect and Copy.** You have the right to inspect and copy your PHI that is contained in a “designated record set.” Generally, a “designated record set” contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

To inspect and copy your PHI that is contained in a designated record set, you must submit your request to the designated contact listed on the first page of this Notice. It is important that you contact the designated contact to request an inspection and copying so that we can begin to process your request. Requests sent to persons, offices, other than the designated contact might delay processing the request. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy your PHI in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. To request a review, you must contact the designated contact listed on the first page of this Notice. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

- **Right to Amend.** If you believe that your PHI is incorrect or incomplete, you may request that we amend your information. You may request that we amend your information by contacting the designated contact listed on the first page of this Notice. Additionally, your request should include the reason the amendment is necessary. It is important that you direct your request for amendment to the designated contact so that we can begin to process your request. Requests sent to persons or offices, other than the designated contact might delay processing the request.

In certain cases, we may deny your request for an amendment. For example, we may deny your request if the information you want to amend is not maintained by us, but by another entity. If we deny your request, you have the right to file a statement of disagreement with us. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

- **Right of an Accounting.** You have a right to an accounting of certain disclosures of your PHI that are for reasons other than treatment, payment, or health care operations. No accounting of disclosures is required for disclosures made pursuant to a signed authorization by you or your personal representative. You should know that most disclosures of PHI will be for purposes of payment or health care operations, and, therefore, will not be subject to your right to an accounting. There also are other exceptions to this right. An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

You may request an accounting by submitting your request in writing to the designated contact listed on the first page of this Notice. It is important that you direct your request for an accounting to the designated contact so that we can begin to process your request. Requests sent to persons or offices other than the designated contact might delay processing the request.





Your request may be for disclosures made up to 6 years before the date of your request, but not for disclosures made before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

- ☐ ***Right to a Copy of This Notice.*** You have the right to request a copy of this Notice at any time by contacting the designated contact listed on the first page of this Notice. If you receive this Notice on our Website or by electronic mail, you also are entitled to request a paper copy of this Notice.

COMPLAINTS

You may complain to us if you believe that we have violated your privacy rights. You may file a complaint with us by calling us at the number listed on the first page of this Notice. A copy of a complaint form is available from this contact office.

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem.

We will not penalize or any other way retaliate against you for filing a complaint with the Secretary or with us.





New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Laura Townsend, City of Fort Wayne, (260) 427-2634.

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

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name City of Fort Wayne		4. Employer Identification Number (EIN) 35-6001029	
5. Employer address 200 East Berry		6. Employer phone number 260-427-2634	
7. City Fort Wayne	8. State IN	9. ZIP code 46802	
10. Who can we contact about employee health coverage at this job? Laura Townsend			
11. Phone number (if different from above) 260-427-2634		12. Email address laura.townsend@cityoffortwayne.org	

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

•As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

All full-time employees

•With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Spouse & Dependent children

☐ We do not offer coverage.

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

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

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

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

☐ **Yes (Continue)**

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No (STOP and return this form to employee)**

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? _____

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

