CITY OF FORT WAYNE
PEOPLE | SERVICE | OPPORTUNITY

*A Stronger Fort Wayne Together*

# 2027 EMPLOYEE BENEFITS GUIDE

HEALTH
WELLNESS
RETIREMENT
SECURITY

PLAN YEAR 2027

*Your Benefits. Your Choices. Your Future.*



HEALTHY PEOPLE | SUPPORTIVE FAMILIES | THRIVING COMMUNITIES | A BRIGHTER TOMORROW

*Where Community Moves Forward*

HUMAN RESOURCES DEPARTMENT
CITY OF FORT WAYNE | CITYOFFORTWAYNE.ORG

# Contact Information

| Coverage | Carrier | Phone | Website |
|---|---|---|---|
| **Medical & Pharmacy** | AGA | 260-489-6447 or 800-888-6472 | www.aga-tpa.com |
| **Provider Network -** Northeast Indiana | Signature Care EPO | 800-666-4449 | www.parkview.com/signaturecaredirectory |
| **Provider Network -** resides outside Northeast Indiana | Cigna | 800-551-7334 | www.myCigna.com |
| **Prescription Drug & Mail Order** | TrueRx | 866-921-4047 | www.truerx.com |
| **Prescription Drug Program** | RxFree4Me | 866-750-2723<br>409-866-5715 Fax | www.RxFree4Me.com |
| **LabCard Program** | LabCorp | 888-522-2677 | 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** | AGA | 260-489-6447 or 800-888-6472 | www.aga-tpa.com |
| **Voluntary Vision** | United Healthcare | 800-638-3120 or 800-839-3242 Provider Locator | www.myuhcvision.com |
| **Health Reimbursement Account (HRA)** | AGA | 260-489-6447 or 800-888-6472 | www.aga-tpa.com |
| **Health Savings Account (HSA) -** for HDHP participants | UMB | 866-520-4472 | HSA.UMB.com |
| **Flexible Spending Accounts (FSA)** | AGA | 260-489-6447 or 800-888-6472 | www.aga-tpa.com |



This benefit guide provides only a summary of your benefits. All services described within are subject to the definitions, limitations, and exclusions outlined in each insurance carrier's or provider's contract.

# 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 |
| **Indiana Public Employee Retirement System** | INPRS | 844-GO-INPRS | www.inprs.in.gov |



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# 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
sandye@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

DeHayes
keystone platform partner



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City of Fort Wayne Human Resources

# 2027 Health Plan Rates

## $1300 Tier 1 Deductible/$2300 Tier 2 Deductible Plan (with Dental)

**Traditional Plan - Signature Care EPO Network****

- Tier 1 $30 OV Co-pay/Tier 2 $35 OV Co-pay
- Tier 1 80/20 Coins, Ind Max OOP $3800 Tier 2 70/30 Coins, Ind Max OOP $6,800
- $15/$40/$60 Rx Co-pay

| MONTHLY RATES | |
|---|---|
| Employee Only | $83.60 |
| Employee + Spouse Secondary* | $117.70 |
| Employee + 1 Primary (Spouse or Child) | $155.10 |
| Employee + Family without Spouse | $167.20 |
| Employee + Family Spouse Secondary* | $181.50 |
| Employee + Family Spouse Primary | $216.70 |

## $3500 Tier 1 Deductible/$4500 Tier 2 Deductible Plan (with Dental)

**High Deductible Health Plan - Signature Care EPO Network****

- Tier 1 100% Coins after deductible
  Tier 2 90/10 Coins, Ind Max OOP $6500
- *$150 ER co-pay and $40/$60 copay on name brand Rx (after deductible has been met)

| MONTHLY RATES | |
|---|---|
| Employee Only | $42.90 |
| Employee + Spouse Secondary* | $59.40 |
| Employee + 1 Primary (Spouse or Child) | $79.20 |
| Employee + Family without Spouse | $84.70 |
| Employee + Family Spouse Secondary* | $92.40 |
| Employee + Family Spouse Primary | $108.90 |

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

**Signature Care EPO Network **Tier Information****
**Tier 1 - Parkview Physicians and Facilities**
**Tier 2 - Lutheran and IU Physicians and Lutheran Facilities**
**(IU Facilities located in Fort Wayne are Out of Network/IU Facilities outside of Fort Wayne are Tier 2)**

## Dental Only

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

| MONTHLY RATES | |
|---|---|
| Employee Only | $14.30 |
| Employee + 1 | $24.20 |
| Family | $36.30 |

**PREMIUMS ARE DEDUCTED ON A BI-WEEKLY BASIS**
To calculate premium cost per paycheck:
Monthly Rate x 12 (months) ÷ 26 (pay periods)

https://www.cityoffortwayne.in.gov/377/City-Benefits

# 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.



This benefit guide provides only a summary of your benefits. All services described within are subject to the definitions, limitations, and exclusions outlined in each insurance carrier's or provider's contract.

# 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.



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# MEDICAL

# Medical Insurance

City of Fort Wayne offers eligible employees and their dependents a comprehensive EPO (Exclusive Provider Organization) health insurance plan administered by Automated Group Administration (AGA).

## Find a Provider

To find a provider visit: www.parkview.com/signaturecaredirectory

Automated Group Administration, Inc.

| TRADITIONAL PLAN - Grandfathered | EPO (Tier 1) | PPO Providers (Tier 2) | Out-of-Network |
|---|---|---|---|
| **Deductible** | $1,300 Indiv / $3,900 Fam | $2,300 Indiv / $6,900 Fam | $4,300 Indiv / $12,900 Fam |
| **Coinsurance** | 80% / 20% | 70% / 30% | 50% / 50% |
| **Out-of-Pocket Maximum** (per cal yr)* | $2,500 Indiv / $5,000 Fam | $5,500 Indiv / $11,000 Fam | $14,000 Indiv / $28,000 Fam |
| **Physician Office Visit** (Visit only)<br>All other services subject to ded & coins. | $30 copay | $35 copay | 50% after deductible |
| **Preventive Services**<br>Office visits/Routine exam, immunizations, prostate exams w/PSA's, well woman exam w/pap, mammogram | $30 copay up to $2,000 benefit, then ded, then 80%<br>Colonoscopy - 100%, no ded | $35 copay up to $2,000 benefit, then ded, then 70%<br>Colonoscopy - 100%, no ded | 50% after deductible<br>Colonoscopy - not covered |
| **Emergency Room** | 80% after deductible | 70% after deductible | 50% after deductible |
| **Urgent Care Visit** (Visit only)<br>All other services subject to ded & coins. | $35 copay | $40 copay | $45 copay |
| **Laboratory Services**<br>*If LabCorp or Quest Select used: 100%, not subject to ded* | 80% after deductible | 70% after deductible | 50% after deductible |
| **Prescription Drugs - Retail /Mail Order**<br>34 day supply / 90 day supply<br>**Member pays difference between generic and brand plus $15 when brand prescribed & generic available, unless physicians mandates "dispense as written"* | Generic - $15 copay / $30 copay<br>*Formulary - $40 copay / $80 copay<br>*Non-Formulary - $60 copay / $120 copay<br>Specialty (34 days) - 100% after ded (Must use Specialty Pharmacy) | | |

- The out-of-pocket limit does NOT include deductibles, copays, balanced-billed charges, pre-cert penalties and excluded charges
- Benefits apply to network retail pharmacies
- Balance billing protection when you use an in-network provider
- In-patient hospital admissions and many out-patient procedures require mandatory notification to Managed Care Concepts: 866-750-2723



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# Medical Insurance

City of Fort Wayne offers eligible employees and their dependents a comprehensive EPO (Exclusive Provider Organization) health insurance plan administered by Automated Group Administration (AGA).

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| HDHP - Grandfathered | EPO (Tier 1) | PPO Providers (Tier 2) | Out-of-Network |
|---|---|---|---|
| **Deductible** | $3,500 Indiv / $7,000 Fam | $4,500 Indiv / $9,000 Fam | $7,500 Indiv / $15,000 Fam |
| **Coinsurance** | 100% / 0% | 90% / 10% | 50% / 50% |
| **Out-of-Pocket Maximum** (per cal yr)* | $0 Indiv / $0 Fam | $3,000 Indiv / $6,000 Fam | $14,000 Indiv / $28,000 Fam |
| **Physician Office Visit** (Visit only)<br>All other services subject to ded & coins. | 100% after deductible | 90% after deductible | 50% after deductible |
| **Preventive Services**<br>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<br>Colonoscopy - 100%, no ded | 100% up to $2,000 benefit, then 90% after deductible<br>Colonoscopy - 100%, no ded | 50% after deductible<br>Colonoscopy - not covered |
| **Emergency Room** | Deductible, then $150 copay, then 100% | Deductible, then $150 copay, then 90% | 50% after deductible |
| **Urgent Care Visit** (Visit only)<br>All other services subject to ded & coins. | 100% after deductible | 90% after deductible | 50% after deductible |
| **Laboratory Services**<br>*If LabCorp or Quest Select used: Discount available* | 100% after deductible | 90% after deductible | 50% after deductible |
| **Prescription Drugs - Retail /Mail Order**<br>34 day supply / 90 day supply<br>**Member pays difference between generic and brand plus $15 when brand prescribed & generic available, unless physicians mandates "dispense as written"* | Must meet deductible before copays apply<br>Generic - $0 copay / $0 copay<br>*Formulary - $40 copay / $80 copay<br>*Non-Formulary - $60 copay / $120 copay<br>Specialty (34 days) - 100% after ded (Must use Specialty Pharmacy) | | |

- The out-of-pocket limit does NOT include deductibles, copays, balanced-billed charges, pre-cert penalties and excluded charges
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# Member Experience

## IMPROVE SATISFACTION AND INCREASE ENGAGEMENT

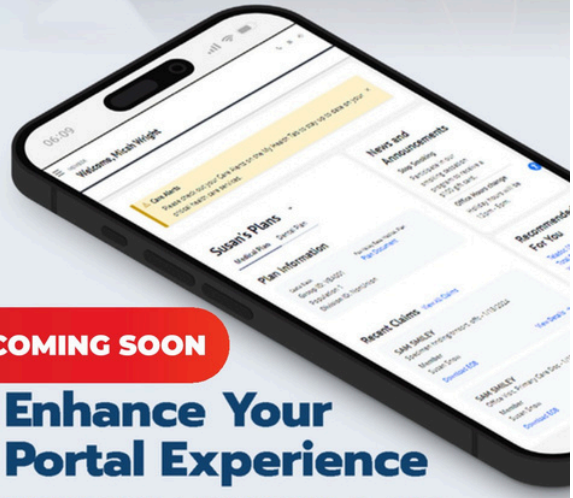
Building a positive member experience is key for healthcare payers to increase member engagement in managing their health, improve member satisfaction and reduce member churn. VBAGateway allows members to access information about their coverage and benefits without picking up the phone to contact Customer Service.

**Members can use the VBAGateway portal to:**

- Access ID cards
- View recent claims and EOBs
- Download and view plan documents
- Use the medical cost estimator to understand the cost of care
- Find a provider in their area
- Contact the plan administrator using the message **center**

Registration is simple and secure.
Members can go to AGA.vbagateway.com to register using their Registration Code, social security number and date of birth.

**REGISTER NOW**




**COMING SOON**

# Enhance Your Portal Experience

## WITH THE VBAMOBILE APP

VBA offers a progressive web app experience that makes it even easier for members to access the information they need anytime from a mobile device. With VBAMobile, all the features of your VBAGateway portal experience are incorporated into an intuitive mobile app that members can access from anywhere.

www.AGA-TPA.com

The Signature Care EPO (Exclusive Provider Organization) Network is dedicated to providing members with the best healthcare providers at the highest level of benefi t coverage when utilizing one of these top-tier facilities.

# NETWORK MAP
# SIGNATURE CARE EPO

Signature Care top-tier facilities as well as in-network facilities and providers are located in the counties indicated on this map.

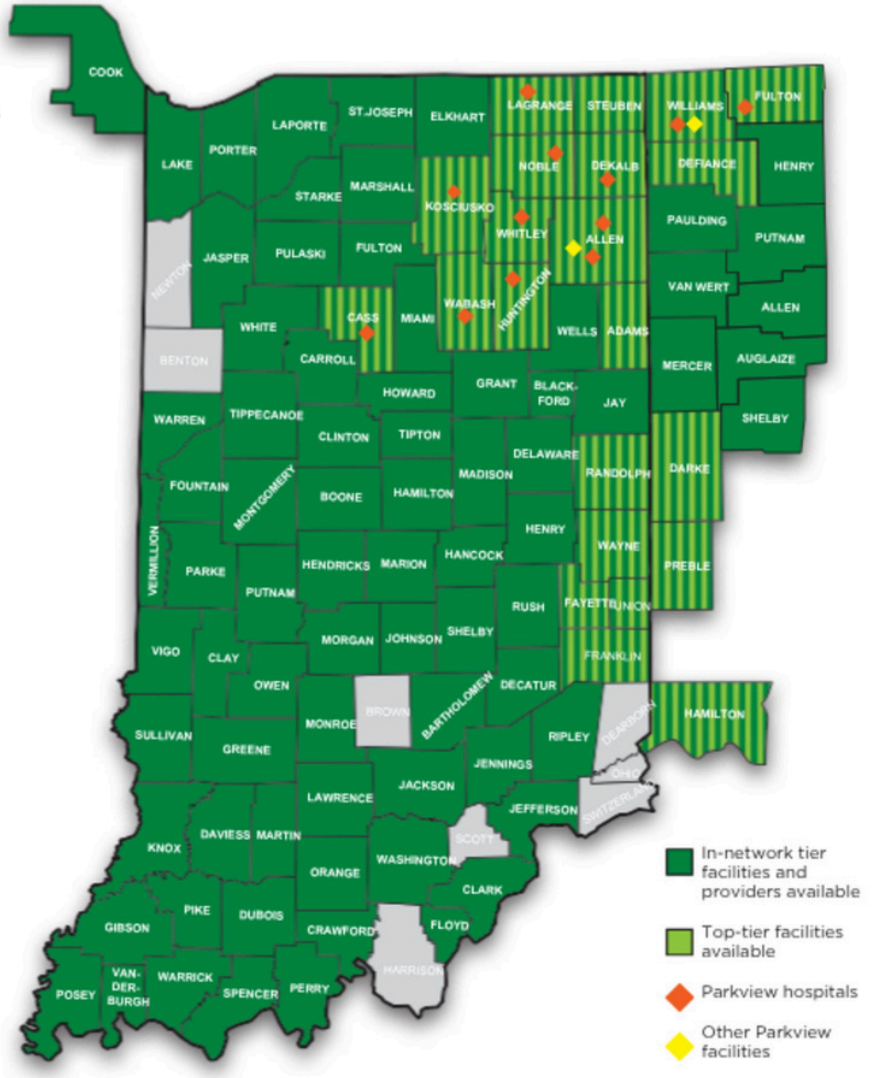
## TOP-TIER/TIER 1 FACILITIES

### Parkview Facilities

Parkview Archbold
Parkview Behavioral Health Institute
Parkview Bryan Hospital
Parkview DeKalb Hospital
Parkview Endoscopy Center
Parkview Hospital Randallia
Parkview Huntington Hospital
Parkview Kosciusko Hospital
Parkview Kosciusko SurgeryONE
Parkview LaGrange Hospital
Parkview Logansport Hospital
Parkview Montpelier Hospital
Parkview Noble Hospital
Parkview Ortho Hospital
Parkview Premier Surgery
Parkview Regional Medical Center
Parkview Southwest
Parkview SurgeryONE
Parkview Wabash Hospital
Parkview Whitley Hospital

### Other Facilities

AdamsMemorial Hospital
Cameron Memorial Community Hospital
Cincinnati Children's Hospital
Lake George Surgery Center
Reid Health
Riverview Health
Surgery Center (ENT)




Visit our online directory at **parkview.com/signaturecaredirectory** to view all providers throughout Indiana and Ohio.

PARKVIEW SIGNATURE CARE

MKTG-32537 (10/26)

trueRx
HEALTH STRATEGISTS

# Manage Your Pharmacy Benefits *Anytime, Anywhere*




## Say *hello* to True Rx+, an Enhanced App and Portal

True Rx+ is more than just a pharmacy app. It's your personalized digital pharmacy experience designed to help you stay informed, save money, and get support when you need it the most.

### What You Can Do With True Rx+

- View your insurance card and plan details
- See your active prescriptions, deductible, and out-of-pocket status
- Compare medication prices at local pharmacies
- Track prior authorizations in real time
- Set refill reminders
- Chat with a live True Rx Health Strategist

## Download True Rx+ *today!*

SCAN ME

trueRx HEALTH STRATEGISTS | WB Rx EXPRESS

# Medication Delivered to Your Door

## Skip the pharmacy line and receive personalized care.

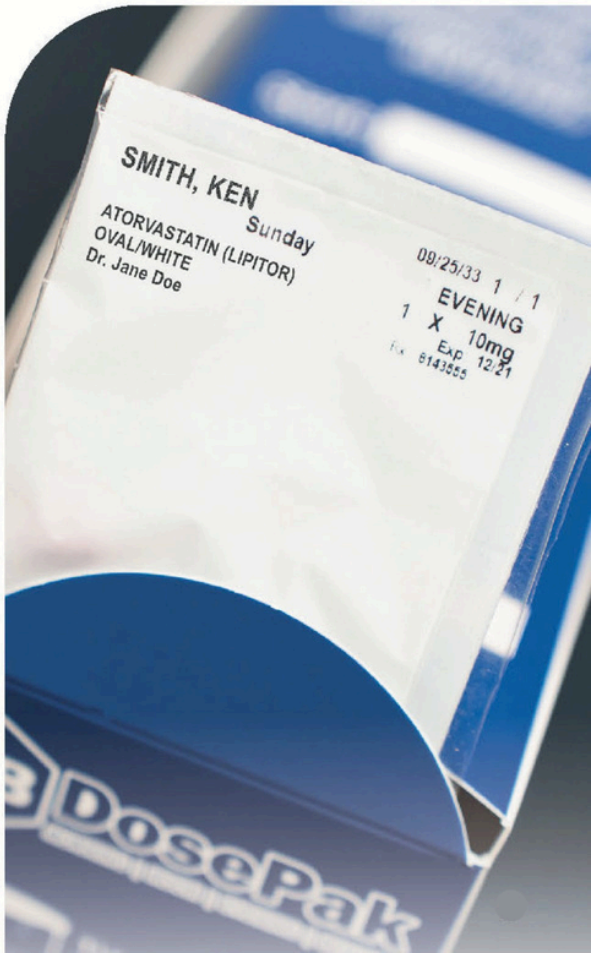
True Rx Health Strategists partners with WB Rx Express to deliver your prescriptions right to your door. With WB Rx Express, you can manage, refill, and get information about your medications with ease, while receiving exceptional service.

Like True Rx, WB Rx Express is a family-run pharmacy serving communities for decades. It's the place to go if you want personalized and friendly service that is convenient and accessible.

## Zero hassles—WB Rx Express makes medication easy

WB Rx Express offers options to simplify your medication management:

- ***Never miss a dose with WB DosePak!***
  Pharmacists sort your medications by day and time, making it easier for you take them exactly as prescribed.
- ***Synchronized refills***
  Sync your medication fills to get them all at once.
- ***Prescription autofill***
  Refills are automatically shipped before you run out.




### *Did You Know?*

By ordering a mail order 90-day supply, stock up and enjoy savings for months to come.

- **98% PATIENT SATISFACTION**
- **99.8% QUESTIONS RESOLVED IN ONE CALL**
- **5 SECOND AVERAGE TIME TO ANSWER**
- **PRESCRIPTIONS SHIPPED IN 24 HOURS***
  *Average turnaround time

## Get Started in Three Easy Steps

step 01

**Go to wbrxexpress.com and click "Become a New Patient".**

step 02

**Complete the online form and click the red "Submit" button.**

You can also set up your account by calling the pharmacy at 833-391-0126.

step 03

**WB Rx Express will contact you within two business days to verify your account and medication information.**

Kindly inform us at least 14 days in advance if you need a refill or wish to cancel your automatic refill.

## Mail Order Medication Prices in the Member Portal

Mail order pricing is integrated with the True Rx+ app and member portal, member.myplantruerx.com. Compare mail order pricing with retail pharmacies in your area.

## Payment Options

WB Rx Express accepts MasterCard, Visa, Discover, and American Express.

## Limitations of Mail Order

- Please use your local pharmacy for a 30-day or less supply of medication.
- Refill orders submitted prematurely may be delayed until the earliest allowable date for processing.
- For your safety, WB Rx Express does not dispense Schedule II controlled substances.

trueRx HEALTH STRATEGISTS | MARK CUBAN CostPlus DRUG COMPANY

# Low-Cost Medication with Personalized Care

## Mark Cuban Cost Plus Drugs is an in-network mail order pharmacy for patients

True Rx Health Strategists has teamed with Mark Cuban Cost Plus Drug Company to provide you with another easy option to get low-cost medications. You can choose to purchase your medications directly through the Cost Plus Drugs website, costplusdrugs.com. You may also access the Cost Plus Drugs website through the True Rx+ app or member portal, member.myplantruerx.com.

**Medications ordered through Cost Plus Drugs will be considered in-network for your insurance plan.**

- The cost of your medication will apply toward your insurance deductibles and out-of-pocket maximums.
- Your co-pay will be applied following your pharmacy benefit plan guidelines.
- You can rely on the True Rx Patient Care team for help with your pharmacy benefit questions.

# It's Easy to Get Started with Cost Plus Drugs

step 01

## Check to see if your medication is available

- Visit CostPlusDrugs.com and click see all medications.
- If you see your medication, follow the steps to create an account.

step 02

## Create your account

- Enter your basic health information, your True Rx pharmacy insurance card information, and your health care provider information.

step 03

## Ask your doctor to send prescriptions to Cost Plus Drugs

- Click how to contact your doctor for information to help when asking your doctor to send in your prescription.

step 04

## Look for your confirmation email and complete your medication order

- You will receive an email from Cost Plus Drugs when they receive your prescription.
- Be sure to check request insurance price to have your prescription process with your True Rx insurance.
- Enter your shipping address and payment information.
- Your medication will be shipped to your doorstep.

tr Assist

# *Unlock Savings* and Optimal Care with True Assist



## Your Trusted Partner for Co-Pay Assistance

As Health Strategists, we take a patient-first approach to health care and cost savings. True Assist helps you reduce your out-of-pocket costs for high-cost medications by providing access to manufacturer co-pay cards and personalized care.

## Expert Medication Guidance and Support

True Rx is dedicated to helping you access any financial assistance you qualify for, potentially reducing your medication costs to as low as $0.*

### Medications Included

- **Specialty**
  All specialty medications.
- **Brands**
  Select brand-name medications.

### Personalized Care

True Rx Care Managers use their clinical expertise to provide the information and comprehensive support needed to enroll in co-pay assistance programs.

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### Contact our patient support team

Available Monday to Friday, 8:00 AM - 5:00 PM EST
Call us at: **866-921-4047**
Email: **hello@truerx.com**

*Eligibility for financial assistance varies based on individual circumstances. Manufacturer payments are recognized by True Assist, and those dollars are not applied to patient accumulators.

trueRx HEALTH STRATEGISTS

866-921-4047
hello@truerx.com
**truerx.com**




RxFree4me

# Your employer has partnered with RxFREE4Me to make several medications 100% FREE.

Most insulin, most prescription brand name drugs, and many more are available to you. RxFREE4Me offers 24/7 customer support with over 1.2 million members served.

Start saving today and enroll in less than 5 minutes.

***Have your Rx and provider info ready***

**Call (866) 750-2723 or email Faxinbox@mcc-tx.com**

**Answer a few brief questions**

**Receive your qualifying Rx FREE**

# 100% FREE TO YOU!

## NO CO-PAY

Nationwide Pharmacy | 24/7 Member Support | RxFree4Me.com

faxinbox@mcc-tx.com | (866) 750-2723 | Fax: (409) 886-5715

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

## 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 |





This benefit guide provides only a summary of your benefits. All services described within are subject to the definitions, limitations, and exclusions outlined in each insurance carrier's or provider's contract.

First Stop Health



THE CITY OF FORT WAYNE

# 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 benefits-eligible employees, 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!

*Costs according to your medical plan may apply for prescriptions.*
**Providers at First Stop Health do not prescribe controlled substances.*
*First Stop Health services are not intended to constitute a health plan.*

## Activate your account

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

**firststophealth.com | 888-691-7867**



www.AGA-TPA.com

# LAB SERVICE PROGRAM

Laborp and QuestSelect are programs offered by your employer that help you and your covered dependents save money on covered lab services when testing is performed at LabCorp or Quest Diagnostics.

**Locate a lab site**

labcorp

For LABCORP

www.labcorp.com

**(888) 522-2677**

QuestSelect™

Formerly Lab Card®

For QUEST SELECT

www.questselect.com

**(800) 646-7788**

www.AGA-TPA.com



# DIRECT IMAGING

Direct Imaging LLC, a subsidy of Direct Care LLC, is a freestanding outpatient imaging services (MRI, CT, Ultrasound and X-rays) facility that offers the most affordable out-of-pocket cost in the area.

Direct Imaging
MRI . CT Scan . Ultrasound . X-Ray

*PROFESSIONAL INTERPRETATION*

All exams are interpreted by Summit Radiology board-certified radiologists

Images and reports are available through our secure, HIPPA-compliant website or via CD

*FAST & EFFICIENT*

Results are sent within 24 hours, but can be sent STAT upon request

## *WHY DIRECT IMAGING?*

- One Flat Rate
- Lower Out-of-pocket Cost
- Advanced Technology
- Same or Next-day Appointment
- Rapid Results
- Comfort and Convenience

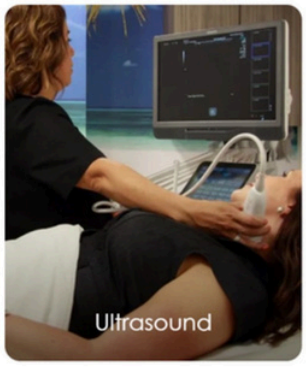
## *OUR SERVICES*

Advanced Diagnostic Imaging Services













**IF YOU HAVE AN IMAGING NEED,**
**LET YOUR PROVIDER KNOW YOU WOULD LIKE TO GO TO DIRECT IMAGING.**

(260) 212-1901 www.DirectImagingLLC.net 1355 Getz Rd, Suite B Fort Wayne, IN 46804

MANAGED CARE CONCEPTS | MCC

# Welcome Back to MCC

Personal healthcare support by telephone

We’re glad to reconnect with you! The same MCC staff you knew before is here to provide the high-quality, personal service you previously experienced. Your Healthcare Navigator can help you understand your care, manage ongoing health needs, and find your next step.

**Our support is telephonic.** We talk with you by phone, so you can connect with us from home, work, or wherever you feel comfortable.

## How MCC can help

- **Chronic care support.** Get help managing diabetes, high blood pressure, asthma, COPD, heart disease, depression, and other ongoing conditions. We help you understand your care plan and work toward your health goals.
- **Inpatient and outpatient precertification.** MCC provides precertification for inpatient hospital stays and outpatient services that require prior approval under your health plan. We coordinate with your provider and help you understand next steps.
- **Help with high-cost medications.** Learn about available options for specialty or expensive drugs. We can help coordinate with your provider and assist with eligible program enrollment, refills, and delivery.
- **Healthcare navigation.** Get help finding providers, preparing questions for your doctor, understanding next steps, and connecting with health plan or community resources.
- **Complex care and hospital recovery.** Our nurses can help you understand discharge instructions, coordinate follow-up care, and work with your providers as you recover.

## What you can expect

**We will reach out.** Expect calls from MCC to reconnect, learn about your needs, and offer support. We may follow up to see how you are doing and help with next steps.

**You can call us, too.** You do not have to wait for an outreach call. Call when you have a question, need help with care or medications, or want to reconnect with your Navigator.

**Save our number!** Add **866-750-2723** to your phone contacts as **Health Care** so you can recognize our calls and easily reach us when you need support.

## Call MCC at 866-750-2723

We look forward to hearing from you and supporting your health again.

Available services and medication options depend on your health plan and eligibility. MCC supports the care you receive from your healthcare providers. For a medical emergency, call 911.

www.AGA-TPA.com

MANAGED CARE CONCEPTS *We Can.*

# HEALTHY TRACK PROGRAM

Successfully managing your life with diabetes can be challenging. Healthy Track is a platform of health care services designed to get and keep you on a “healthy track”. This is accomplished through the FDA approved Blood Glucose Monitor which provides real time data and comprehensive Nurse Navigator support.

Additional supplies available: test strips & lancets, continuous glucose monitors (CGM) and insulin pumps.

The Blood Glucose Meter accurately tests glucose levels and automatically sends the results to the patient’s secure and personal on-line portal, which can be shared with healthcare professionals or individuals involved in patient care. The meter has an intuitive user interface and is easy to use, including a color LCD screen, rechargeable battery and the ability to store up to 450 readings.

The portal system eliminates the need for traditional paper logbooks and contains features for running test history reports. In addition, the system can be programmed to send text message alerts of test results to any mobile phone or to your physician!




*Managed Care Concepts*

1-866-750-2723

Hours Monday - Friday 8:00 - 4:00

www.AGA-TPA.com




# CARELINK

## (888) 604-DMED

## YOUR DME AND SUPPLIES: FREE!*

### RESPIRATORY DME & SUPPLIES

- **CPAP/BiPAP** and supplies like filters and tubing
- **Nebulizer**
- **Oxygen concentrators**

### OTHER DME & SUPPLIES

- **Back Brace**
- **Ostomy Supplies**
- **And hundreds more!**

*Not all plans cover these benefits at 100%. Review your Plan Document prior to receiving services.

AGA Automated Group Administration, Inc.

CARELINK DME | M-F, 8 a.m. - 5 p.m. CT | (888)604-DMED (3633)

www.AGA-TPA.com

Daavlin

# HOME PHOTOTHERAPY

Phototherapy is a safe and highly effective treatment for such skin diseases as psoriasis, eczema, and vitiligo, as well as many others. It can take place in a clinical setting or be prescribed for use in the patient's home. For best results, phototherapy treatments need to occur about three times a week for several weeks to months depending on the disease. Home phototherapy is popular because it is easy for patients to maintain consistency in their treatment service.







Contrary to other therapies, phototherapy can be prescribed for many types of patients. Pregnant women, children, elderly, those with compromised immune systems can all benefit from this safe & effective treatment. Side effects are mild and temporary. Examples of side effects are dry skin, itching or occasional erythema.

**The program is provided to you at a substantial discount - in some cases at NO COST!**

**1-800-322-8546**

Most phototherapy performed today uses Narrowband UVB. This is the most therapeutic band of light and treatments are quite brief, typically just seconds to minutes in duration. Patients simply expose the affected skin to the light - there is no need for other drugs or medication. Once the treatment is over, patients go about their day as normal.



800-322-8546
www.Daavlin.com

www.AGA-TPA.com

MANAGED CARE CONCEPTS *We Can.*

# CHRONIC CARE PROGRAM

Managed Care Concepts Chronic Care Program is a set of coordinated services designed to help members manage chronic medical conditions such as asthma, diabetes, hypertension, congestive heart failure, coronary artery disease and/or obesity.







## 100% CONFIDENTIAL

## NO COST TO YOU

## STRICTLY VOLUNTARY

*Call now to start your journey to better health!*

**1-866-750-2723**

**Reducing Risk by Focusing on:**
Awareness/Education | Nutrition Exercise Strategies | Behavior Modification Program | Healthy Lifestyle Coaching | Medical Follow-up

**Program Includes but not limited to:**
Virtual Coaching by trained nurse coaches
Unlimited inbound calls to your nurse coach
Educational Materials mailed to your home or via email
Coordination of services with physicians and/or other healthcare providers

# Because your hearing health is part of your overall health.



## EPIC Hearing Healthcare is here to make it easier

1 **Contact EPIC to schedule an initial hearing exam and consultation.**

Treat hearing loss and protect your hearing health. Call 1-866-956-5400 to schedule an appointment.

2 **Your provider will help you find the perfect solution.**

At your consultation and exam, your provider will assess your hearing and provide a personalized recommendation. Plus, they'll be able to answer any questions you have.

## Hearing Benefit Plan

**Hearing Plan Name:**

**Automated Group Administration, Inc. (AGA)**

## Plan Details

**Save up to 50% off a wide selection of hearing aids and services.**

## Get started

*Call EPIC to schedule an appointment:*

**1-866-956-5400**

*Learn more about your hearing health:*

**EPICHearing.com**

Be sure to have your hearing plan name handy when you call to schedule your appointment.

Continued.

# Hear better, live better

Treating hearing loss may help you rediscover parts of your life that may have felt missing — including engaging in daily activities and staying connected to the people you love. You'll also support your long-term health and can potentially reduce the risk of diseases such as dementia.[1]

## Good-to-know details:

- You have 60 days to try out hearing aids purchased from a provider
- Your plan includes a 3-year extended warranty for repairs and a one-time loss or damage replacement[2]
- Schedule up to 3 follow-up visits at no cost,[3] with additional support available

## Choose from high-quality hearing aids, including:

Relate, Beltone, oticon, PHONAK, ReSound GN, unitron, signia, WIDEX, Starkey

## Ready to go?

**Call 1-866-956-5400**
**8 a.m. – 8 p.m. CT,** Monday through Friday
Be sure to have your hearing plan name handy.

**Visit EPICHearing.com** to learn more

**Scan QR code**
using your smartphone's camera

[1] **Journal of the American Medical Association,** Hearing Loss and Dementia Prevalence in Older Adults in the US. 1/10/2023

[2] One-time professional fee may apply.

[3] Hearing aids purchased in the Silver technology level will receive 1 follow-up visit.

All trademarks property of respective owners.

Hearing aids must be ordered through the Ear Professionals International Corporation (EPIC) Hearing Healthcare provider network. Price per hearing aid, based on suggested manufacturer pricing. Hearing aids ordered through providers outside of the EPIC Hearing Healthcare provider network will not be covered. Home delivery may not be available on all plans. EPIC Hearing Healthcare complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

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CITY OF FORT WAYNE HUMAN RESOURCES

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

WELLNESS & lifestyle management

## 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% PAID TOBACCO CESSATION**

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.

Benefits & Wellness Department | Laura Helmkamp @ 427.2634 I Katie Adams @ 427-6910

CITY OF FORT WAYNE HUMAN RESOURCES

# GUIDELINES FOR HEALTHY LIFESTYLE BENEFIT REIMBURSEMENTS

WELLNESS & lifestyle management

## 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 Automated Group Administration (AGA) 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 Automated Group Administration (AGA). 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.

**AGA Member Portal**

www.aga-tpa.com

| Plan Provisions | |
|---|---|
| **Annual Deductible**<br>Basic & Major Services | $50 Individual / $150 Family |
| **Calendar Year Maximum**<br>Basic & Major Services only (does not include preventive) | $1,200 per individual |
| **Preventive Services**<br>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**<br>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**<br>Inlays, gold fillings, crowns, dentures and precision attachments, fixed bridgework, surgical treatments for disease of the gums and mouth tissues, implants | 60% |





This benefit guide provides only a summary of your benefits. All services described within are subject to the definitions, limitations, and exclusions outlined in each insurance carrier's or provider's contract.



# VISION

City of Fort Wayne

UnitedHealthcare®

# Vision Benefit Summary

Customer 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 lenses** [8] 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 lenses**[3] 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 Glasses2 | $125.00 |
| Necessary Contacts in Lieu of Eye Glasses3 | $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<br>Exam, Single Vision &<br>Covered-in-Full Frames | $275.00 | $97.98 | $177.02 |
| Employee+ One<br>Exam, Single Vision &<br>Covered-in-Full Frames | $550.00 | $192.98 | $357.02 |
| Employee+Child(ren) 6<br>Exam, Single Vision &<br>Covered-in-Full Frames | $825.00 | $234.31 | $590.69 |
| Employee+ Family [7]<br>Exam, Single Vision &<br>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 towardthe 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.



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**Vision Benefit Card**

UnitedHealthcare

City of Fort Wayne

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

United Healthcare

## 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**

United Healthcare

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。

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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 , 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 haveaccesstodiscounts 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**

**Save**

**20%**

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




## Learn more.

Contact your UnitedHealthcare representative.

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 problems[3]

## 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. 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?sso=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.

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# HEALTH REIMBURSEMENT ACCOUNT

# DENTAL & VISION SERVICES

1. **What is a health reimbursementaccount(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 Automated Group Administration (AGA) 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<br>HSAs | Flexible "Spending" Account<br>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 toearninterest | Does not earn interest |
| Annual Contribution: | In 2027, the single coverage limit is $4,500 and the family coverage limit is $9,000. | Limit is $3,500 |
| 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 | |
|---|---|
| **2026** | Individual - $4,400 / Family - $8,750 |
| **2027** | Individual - $4,500 / Family - $9,000 |
| **HSA Catch-Up Contribution** **(age 55 & older)** | $1,000 |





This benefit guide provides only a summary of your benefits. All services described within are subject to the definitions, limitations, and exclusions outlined in each insurance carrier's or provider's contract.

UMB Healthcare Services

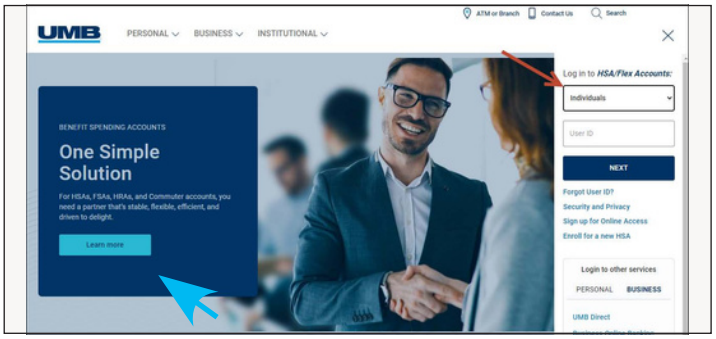
EMPLOYER NAME
City of Fort Wayne
ENROLLMENT VERIFICATION NUMBER
THA0001 135359

# 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

Beforeproceeding, 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 theresultsduringthesession, you will get one of the followingscreens:

**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 debitcard including additionalcardsyou ordered duringyouronlineenrollment 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).

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# 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 |
|---|---|---|
| 2026 | $4,400 | $8,750 |
| 2027 | $4,500 | $9,000 |

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

### 2. INTEREST AND INVESTMENT[1] 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** for more details on current interest rates and how investment options work.



### 3. TAX[2] 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.** Someproviders may require payment at thetimeof service. And your total bill may vary depending on whether or not you've met your deductible. Once you are logged into your accounton **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.*

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Funds in an HSA Deposit Account are held at UMB Bank, n.a., Member FDIC.

UMB Healthcare Services

# 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]

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 | 2026 | 2027 |
|---|---|---|
| Individual | $4,400 | $4,500 |
| Family | $8,750 | $9,000 |

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

FOR MORE INFORMATION:
UMB .com/HSA
866.520.4HSA (4472)

## Invest for the future

Learn more about UMB HSA investments[2].

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)



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

*[1] 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.*

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

*[2] UMB Investment Management selects mutual funds in various asset classes for inclusion in the UMB HSA Saver Investment Program. UMB Custody Services provides safekeeping and settlement of the mutual fund investments 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.*

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UMB Healthcare Services

# 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 asidemoney 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 2026, the maximum contribution amount from all sources—your contributions, your employer's contributions and any other sources—is $4,400 for individual coverage and $8,750 for family coverage. For 2027, the maximum contribution amount will be $4,500 for individual coverage and $9,000 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 HSA'S WORK?

You choose how much you'd liketo 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 reachtheout-of-pocketmaximumassociated with the a 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 2026, the maximum contribution amount from all sources—your contributions, your employer's contributions and any other sources—is $4,3\400 for employee-only coverage and $8,750 for family coverage. For 2027, the maximum contribution amount will be $4,500 for individual coverage and $9,000 for family coverage.

### Q8: HOW DO I CONTRIBUTE TO THE ACCOUNT?

The Welcome Kit you will receive from UMB once youopen 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
- Dental treatments, exams or cleaning costs
- Prescription and over-the-counter drug costs
- Vision expenses such as contact lenses or glasses
- Chiropractic or acupuncture fees
- 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 topay 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, youmay transfer the balancefrom 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).**

*This material is provided for informational purposes only and all opinions represent UMB Healthcare Service's judgment as of the date this material was published and is subject to change at any time without notice. You should not use this material as a substitute for your own judgment, and you might want to consult professional advisors before making any tax, legal, financial planning or investment decisions. This material contains no investment recommendations and you should not interpret this material as investment, tax, legal or financial planning advice.*
*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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*[1] 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.*
*[2] UMB Investment Management selects mutual funds in various asset classes for inclusion in the UMB HSA Saver Investment Program. UMB Custody Services provides safekeeping and settlement of the mutual fund investments 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 Healthcare Services

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

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## 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.

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*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.*

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UMB Healthcare Services

# 2027 HSA Contribution Rules*

| Spouse 2** \ Spouse 1** | No Coverage | Self-Only non-HDHP | Self-Only HDHP | Family non-HDHP | Family HDHP |
|---|---|---|---|---|---|
| **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 $4,500[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 $9,000[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 $9,000[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 $4,500[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 $9,000[1], but spouse 2 is not eligible to contribute to an HSA. |
| **Self-Only HDHP** | Spouse 2 is eligible and may contribute up to $4,500[1], but spouse 1 is not eligible to contribute to an HSA. | Spouse 2 is eligible and may contribute up to $4,500[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 $4,500[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 $4,500[1] to an HSA. | Both people are eligible and treated as if they have family coverage. Their maximum combined contribution of $9,000[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 $4,500[1] to an HSA. | Neither person is eligible to contribute to an HSA. | Spouse 1 is only eligible to contribute up to $9,000[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 $9,000[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 $9,000[2] must be divided between them based on agreement.[3] | Spouse 2 is eligible and may contribute up to $9,000[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 $9,000[2] must be divided between them based on agreement.[3] | Spouse 2 is only eligible to contribute up to $9,000[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 $9,000[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 constituteinsuranceproducts, whichare not offeredby UMBBank, 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.*

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Funds in an HSA Deposit Account are held at UMB Bank, n.a., Member FDIC.

# 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 Automated Group Administration (AGA). This chart shows the eligible expenses and how much you can contribute each year.

| Account Type | Eligible Expenses | Annual Contribution Limits |
|---|---|---|
| Health FSA<br>(General Purpose) | • Deductible and coinsurance amounts<br>• Office visits and ER co-payments<br>• Prescription drug co-payments<br>• Durable medical equipment<br>• Hearing aids<br>• Dental treatment and orthodontia<br>• Eyeglasses and contact lenses<br>• Contact lens cleaning supplies<br>• Laser vision corrective surgery<br>• OTC items not containing medicine (band aids) | $3,400 |
| Health FSA<br>(Limited Purpose) | • Dental treatments (fillings, crowns)<br>• Orthodontia<br>• Prescriptions eyeglasses<br>• Contact lenses<br>• 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.



This benefit guide provides only a summary of your benefits. All services described within are subject to the definitions, limitations, and exclusions outlined in each insurance carrier's or provider's contract.

# Flex Web Portal Account Set-up

There is a website you can go to for checking your card balance or for looking at recent flex transactions.

Below are the instructions for signing onto the website your first time:

- **Important!!!** If you previously created an online account you will not be able to create a new account. If you are unable to create an account, send an email to flex@aga-tpa.com and ask for your previously created username and a temporary password.

- For privacy and security reasons, before you can create an online account, your email address must be registered. Please email your name, employer, email address and cell phone number to flex@aga-tpa.com. The response will not be immediate.

- You will receive an email response notifying you your information has been registered.

- After you receive your email, go to the web portal. The address is https://aga.wealthcareportal.com. Do not enter www before the address.

- On the login screen, click the Register button towards the bottom of the page.

- Enter your first name, last name and zip code in the appropriate boxes and click next. Use the names and zip code as shown in the email you receive indicating your email has been registered.

- If it asks for an employer id, enter **AGA6650**. It may not ask.

- The next step is to receive a confirmation. **Select to have the confirmation code sent as a text to your cell phone rather than an email,** click Next.

- When you receive the verification code email, enter the 6 digit code and click Next.

- On the next screen enter a user name you create. It can be letters and numbers only. Enter your email address. Create and enter a password and enter to confirm the password. Click Next.

- The next screen is to select and answer your security questions.Click Next when completed.

- On the next screen confirm your email address, click Next.

- The next screen shows the information you entered and gives you a chance to correct. Once finished click Submit and you will be logged in.

**Be sure to register your cell phone number in your account.**

Once you have successfully signed in to the new portal, be sure to click on the Sign-in button in the Alerts section where you can register your cell phone number. This will allow you to retrieve your flex balance with a simple text and receive text messages with your code for the Two-Factor authentication.

**How do I ge tmy flex balance texted to me?**

One of the exciting features with the new portal is the ability to have your flex balance sent to you via text. This will only work if you have registered your cell phone number in the portal. See the above section on how to register your cell phone number. Once your cell phone number is registered, you can text the letters **BAL** to 97487 and you will receive a return text with your balance.

**What if I don't remember my username or password?**

Until you have successfully signed in to the portal at least once, the "Let us help" links to retrieve your username or reset your password will not help you to sign on. After you have successfully signed in to the new portal at least once, you can use the "Let us help" links to retrieve your username and create a new password.

**What if I get an error signing in?**

Try again to make sure the username and password were entered correctly. If you still have the issue, your account may be locked and we will need to reset it. Please send an email to flex@aga-tpa.com and we will reset your account and send you your username and a new password.

**Two-Factor authentication.**

The new portal utilizes two factor authentication for extra security to protect your data. When you have successfully entered your username and password, you will go to a screen for you to choose how to receive the authentication code. The default is an email to the address associated with your account or a text via your cell phone. You can choose to have it via text by clicking on the drop-down menu in the box that says email. If you have registered your cell phone number, see section below, you can select the text message option.

**Problems or Questions?**

If you are having problems logging into the portal or have questions, please email flex@aga-tpa.com and indicate the problem or question you may have and a contact phone number.



# 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<br>**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<br>**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<br>**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<br>**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**<br>• Increments of $10,000 to a max of $500,000<br>• Guaranteed issue up to $200,000 |

| Voluntary Life/AD&D Insurance for your dependents | |
|---|---|
| **Spouse**<br>• Increments of $5,000 up to $250,000 max, not to exceed 50% of employee amount<br>• Guaranteed issue up to $30,000 | **Child(ren)***<br>• Increments of $2,000 up to $10,000 maximum<br><br>*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<br>• Benefits begin on the 8th day for accident or sickness<br>• 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<br>• 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.

SYMETRA
RETIREMENT | BENEFITS | LIFE



This benefit guide provides only a summary of your benefits. All services described within are subject to the definitions, limitations, and exclusions outlined in each insurance carrier's or provider's contract.

Symetra Life Insurance Company
First Symetra National Life Insurance Company of New York

SYMETRA
RETIREMENT | BENEFITS | LIFE

# Support for life's challenges

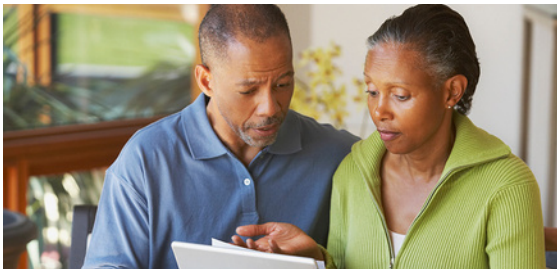
## Symetra SupportSM

## Services to help when needed most

**FOR GROUP LIFE INSURANCE**







# Symetra SupportSM

Whetheryou're managing a lovedone's finalaffairs, 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.**
Allother 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,dentaland pharmacyreferrals:** 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*

- **Emergencytravelarrangements 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-triptravel 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 fo rall services provided by Identity Theft Assistance. Identity theft s 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?

Youand youreligible dependents,aswell as anybeneficiariesnamed 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.

*Continued >*

# EstateGuidance®

## Planning for the future



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

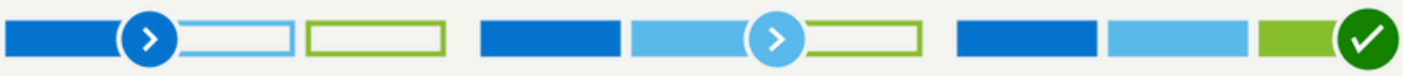
**We understand that drafting a will and a living will can be a complicated and expensive process.**
EstateGuidance® eliminates the hassle and high costs with a simple, secure and affordable online tool.

## A better way to secure your legacy

- **It's fast:** Preparingan 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 growswith 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 willand 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.

## Livingwill 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.

## 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.





# 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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ON CALL INTERNATIONAL

Symetra Life Insurance Company
First Symetra National Life Insurance Company of New York

SYMETRA
RETIREMENT | BENEFITS | LIFE

# Support for life's many challenges

## Symetra Support℠

### 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 DisabilityGuidance**SM**—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.

**First-time users, follow these simple steps:**

①Go to guidanceresources.com and click "Register."
②Provide your organization web ID: **SYMETRA**
③Create 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.

## 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.

**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 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

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] InCalifornia, counseling sessions arelimitedtothree sessions in a six-month period.

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

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**www.symetra.com/ny**

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ComPsych

# 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.

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-choosing-a-medigap-policy-a-guide-to-health-insurance-for-people-with-medicare.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 (added to Daily Stay) | Payable per day up to 30 days | $200 |

| Other Benefits | | |
|---|---|---|
| Well Child Benefit | Payable for maximum of 4 days per child before child reaches age 1 | $50 |

## 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 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 may have a 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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All Employees not eligible in another group

# Group Accident Insurance



## How does it work?

Accident Insurance provides 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.

## 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.

## 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

## How much does it cost?

| Your semi-monthly premium | |
|---|---|
| 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 (one ear) | $6,000 |
| 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 (added to Admission) | $1,000 |
| Daily Stay (365 days) | $200 |
| Daily Stay – Hospital ICU (added to Daily Stay) | $200 |
| Short Stay | N/A |

## Injury

| | |
|---|---|
| Burns | |
| 2nd Degree Burns - At least 5%, but less than 20% of skin surface | $500 |
| 2nd Degree Burns - 20% or greater of skin surface | $1,000 |
| 3rd Degree Burns - Less than 5% of skin surface | $2,000 |
| 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 |

## Injury

| | |
|---|---|
| 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 | |
| Ankle bone or bones of the foot (other than toes) | $1,650 |
| Collarbone (acromioclavicular and separation) | $325 |
| Collarbone (sternoclavicular) | $825 |
| Finger or Toe (Digit) | $150 |
| Hand (other than Fingers) | $500 |
| Elbow joint | $500 |
| Wrist joint | $500 |
| Shoulder | $500 |
| Hip joint | $3,375 |
| Knee joint (other than patella) | $1,650 |
| Kneecap (patella) | $500 |
| Lower Jaw | $500 |
| Incomplete Dislocation - Payable as a % of the applicable Dislocations benefit | 25% |
| Eye Injury | |
| Eye Injury | $200 |
| Fractures | |
| Ankle (lower tibia or fibula) | $450 |
| Foot or Heel (other than Toes) | $450 |
| Bones of the Face or Nose (other than Lower Jaw, Mandible or Upper Jaw, Maxilla) | $675 |
| Collarbone (clavicle, sternum) or Shoulder Blade (scapula) | $450 |
| Finger or Toe (Digit) | $225 |
| Forearm (olecranon, radius, or ulna), Hand, or Wrist (other than Fingers) | $450 |
| Hip or Thigh (femur) | $3,375 |
| Kneecap (patella) | $450 |
| Leg (mid to upper tibia or fibula) | $1,350 |
| Lower Jaw, Mandible (other than alveolar process) | $450 |
| Pelvis | $1,350 |
| Rib | $450 |
| Tailbone (coccyx), Sacrum | $450 |
| Vertebral Processes | $450 |
| Skull (except bones of Face or Nose), Depressed | $4,500 |
| Skull (except bones of Face or Nose), Non-depressed | $2,250 |

## Injury

| | |
|---|---|
| Upper Arm between Elbow and Shoulder (humerus) | $675 |
| Upper Jaw, Maxilla (other than alveolar process) | $675 |
| Vertebrae, body of (other than Vertebral Processes) | $1,350 |
| 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 Visits |
| Prescription Drug | $25 |
| Prescription Benefit Incidence per covered accident | 1 Per Insured |
| Rehabilitation or Subacute Rehabilitation Unit | $50 |
| Therapy Services (chiro, speech, PT, occ) | $25 |
| Therapy Services Maximum Days | 15 Days |

## 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 |

# SCHEDULE OF BENEFITS

## Surgery

| | |
|---|---|
| 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

| | |
|---|---|
| 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 |

## Treatment

| | |
|---|---|
| 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 |
| 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 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 may have a 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-choosing-a-medigap-policy-a-guide-to-health-insurance-for-people-with-medicare.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.

**End of 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

THIS IS A LIMITED BENEFITS POLICY

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 GAC16-1 et al. and GAC16-2 and Policy Form GAP16-1 et al. in all states 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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All Employees not eligible in another group

# 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

- Amyotrophic Lateral Sclerosis (ALS)
- Dementia, including Alzheimer's disease
- Multiple Sclerosis (MS)
- Parkinson's disease
- Functional loss

### Supplemental conditions

- Loss of sight, hearing or speech
- Benign brain tumor
- Coma
- Permanent Paralysis
- Occupational HIV, Hepatitis B, C or D

**Paid at 25%:**

- Infectious Diseases

Please refer to the certificate for complete definitions of these covered conditions. Coverage may vary by state. See exclusions and limitations.

## 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<br>Spouse coverage: $5,000<br>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: $20,000<br>Spouse coverage: $10,000<br>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 |

| Semi-monthly costs | | |
|---|---|---|
| Age | Employee coverage: $30,000<br>Spouse coverage: $15,000<br>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 |

**Active employment:** You are considered in active employment if, on the day you apply for coverage, you are being paid regularly for the required 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 may have a 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-choosing-a-medigap-policy-a-guide-to-health-insurance-for-people-with-medicare.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 Covered Loss that occurs while an Insured is legally incarcerated in a penal or correctional institution.

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

# 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.

### 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

## How can Living Care benefits help?

- Adult daycare
- Assisted living or nursing home
- Prescription drugs
- Gas for transportation (to and from treatment)
- Cash to a family member to assist in your care

[1]Access 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.

# 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 Resto ra t i o n**

### 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

[1]The 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.<br>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. |
| | Restoration of Benefits Rider - Restores 50% of the death benefit for the beneficiary in the event the Acceleration for Chronic Illness Rider is exhausted. |
| Spouse | 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. |
| | Restoration of Benefits Rider - Restores 50% of the death benefit for the beneficiary in the event the Acceleration for Chronic Illness Rider is exhausted. |
| Dependent(s) | 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.**

almost 70%

https://bit.ly/3uTPdxs

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**

ATLANTIC AMERICAN Employee Benefits

## Easy access to coverage

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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 LIfeine 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 thoseliving inyour 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'sEAP services are confidential and noinformation about you,yourparticipation 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?

Thegoal of EAP services is to helpaddress your struggles, concerns, and stressors before theyget to thepoint 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?

Incasesregarding joint custody, we askthat bothparentssignconsentforthechildtoreceivecounselingservices from Parkview EAP prior to the child being seen.

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

Anyonelivinginyour household, included spousesand children,areeligibletoreceive 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?

Giveus 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



Parkview Employee Assistance Program

# HELPINGYOUWEATHERLIFE'S STORMS.

Whenfacing life'sstorms,it'scomfortingtoknowthatyouhave somewhere to turn.

## An important resource

Nooneis immuneto 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

Allof ourEAPservicesare 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/EmployerSolutions** 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

MKTG-32503 (09/2021)

## Help in any situation

The Parkview Employee AssistanceProgram 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 youor 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.

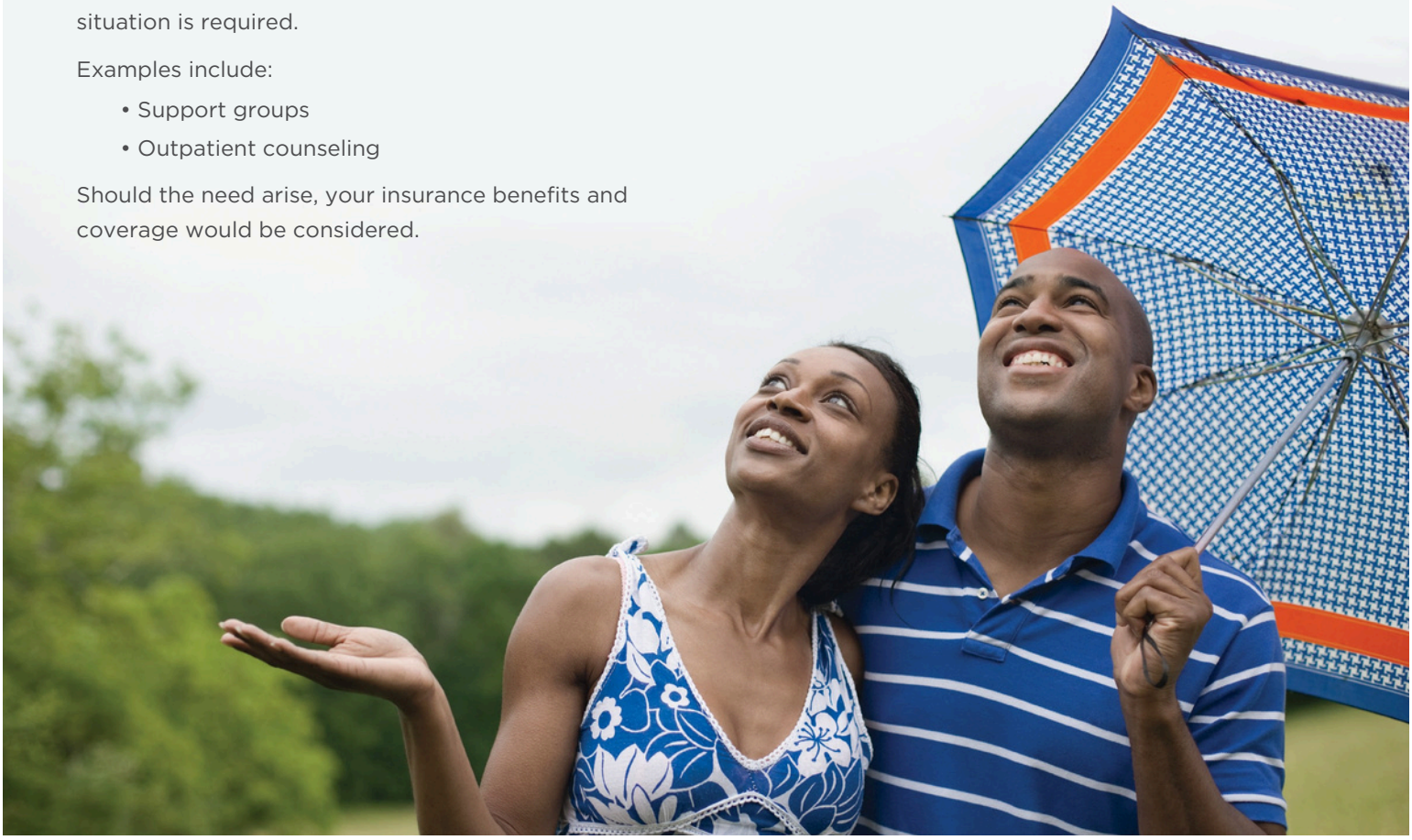
Your confidential EAP services are provided by your employer at no cost to you.

## Flexible

TheParkviewEmployee 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**



**Osaic Wealth**
Mark Bresnahan/Jeramie Shamp
260.637.0800

Lincoln Financial®

# Understanding your governmental 457(b) plan

## Q&A: Know the basics

### What's a 457(b) plan?

A 457(b) plan is a tax-advantaged retirement plan meant to help you save for the future. Contributions are taken directly from your pay and 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-advantaged growth.** You don't pay taxes on pretax 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 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.

## Q&A: Receiving tax benefits

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

Yes. You can save using pretax contributions, Roth contributions if your plan allows, or both.

| Topic | Pretax contributions | Roth contributions[1] |
|---|---|---|
| **How it works** | Contributions are made before taxes are paid, lowering your current taxable income. | Contributions are made after taxes are paid, meaning you don't get an immediate tax break. |
| **Tax advantages** | You get an immediate tax break in the year you make the contribution, but you'll pay income taxes on withdrawals. | You pay income taxes up front, but qualified withdrawals, including contributions and earnings, are tax-free. |
| **Considerations** | Consider if you expect to be in a lower tax bracket during retirement and want to reduce your current taxes. | Consider if you anticipate being in a higher tax bracket during retirement and prefer to pay taxes now and withdraw money tax-free later. |

[1] A distribution is considered "qualified" if your Roth account was established for at least five years and you are at least age 59½ at the time of the withdrawal, or the withdrawal is due to death or total disability. If you do not meet this qualified distribution criteria, earnings will be subject to income tax.

# Q&A: Making contributions

## How do I make contributions?

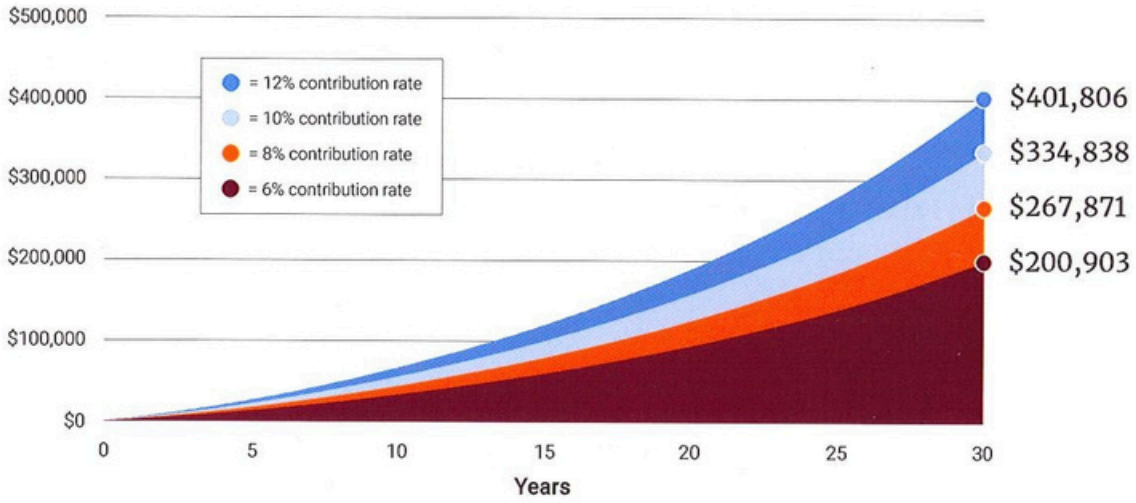
Once you're eligible, complete the necessary forms or enroll online, if possible. Contributions will be withdrawn automatically from your paycheck. You can change or discontinue contributions as allowed by your plan.

## 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 food delivery or subscription services — 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 you, but even a small amount can grow over time. Challenge yourself to save an additional 2% each year — building up to a savings rate of 10% to 15% or more.




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. 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.

## Are there limits to the amount I can contribute?

Yes. Federal tax laws limit employee and employer contributions. Your total contributions with your current and prior employers can't exceed the annual limit. Visit LincolnFinancial.com/IRSlimits or IRS.gov for the most current information.

In the year you turn age 50, you may be eligible to make catch-up contributions. Starting in 2026, if you're considered a highly paid individual (HPI) you must make catch-up contributions as Roth, or your plan may not permit catch-up contributions. Contact your retirement plan representative or your Human Resources department for more information.

[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.

# Q&A: Accessing your account before retirement

## 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. You may owe income taxes since a cash distribution is generally subject to 20% withholding and will be taxed as ordinary income in the year you withdraw it.

## 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.

## 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 keep your beneficiary information up to date.

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Your tomorrow.
Our priority.®

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

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

**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.

Variable annuities sold in New York are issued by Lincoln Life & Annuity Company of New York, Syracuse, NY, and distributed by Lincoln Financial Distributors, Inc., a broker-dealer. For all other states, variable annuities are issued by The Lincoln National Life Insurance Company, Fort Wayne, IN, and distributed by Lincoln Financial Distributors, Inc., a broker-dealer. **The Lincoln National Life Insurance Company does not solicit business in the state of New York, nor is it authorized to do so. Contractual obligations are subject to the claims-paying ability of the appropriate issuing company.**

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| |
|---|
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| Not guaranteed by any bank or savings association |
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POD ADA 6/26 **Z08**
**Order code: DC-457-FLI002**

Lincoln Financial℠

# A small increase can add up

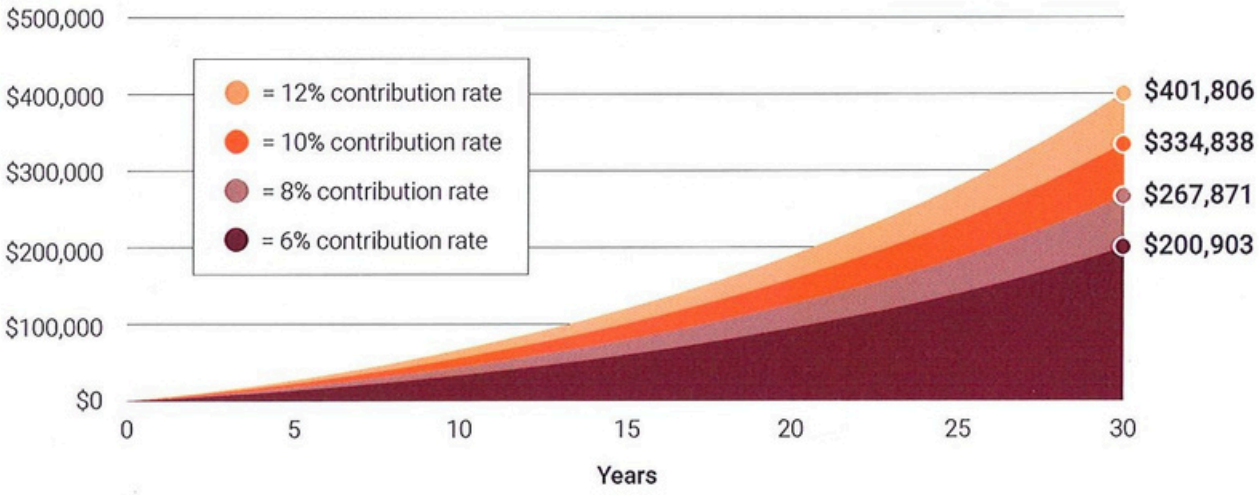
Increasing your retirement plan contributions every year can have a significant impact over time. Even small increases can add up and help you reach your goals. See how contributing more may affect your savings, assuming a 6% return:

| Monthly increase | Potentially adds |
|---|---|
| $50 | $50,000 in 30 years |
| $100 | $100,000 in 30 years |
| $150 | $151,000 in 30 years |

## Your potential upswing

Just a 2% increase in your contribution rate may substantially boost your long-term savings.

### Saving more adds up




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. Any applicable taxes due upon withdrawal (including a 10% tax for amounts withdrawn prior to age 59½) will reduce the results shown. The type of account determines what, if any, taxes are due. 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. It is possible to lose money investing in securities.

Contact your retirement plan representative to learn more.

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POD ADA 12/24 **Z16**
**Order code: DC-INCR-FLI005**

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# 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<br>8 years for specified elected positions | Immediate |
| **Contributions** | • The employer pays 100%.<br>• The INPRS Board of Trustees determines the employer contribution rate annually.<br>• No member contributions. | Mandatory 3% of gross wages paid by:<br>• Employer, or<br>• Employee, or<br>• Shared by both employee and employer.<br>Voluntary Contributions[1]<br>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:<br>• Stable Value Fund<br>• Money Market Fund<br>• Fixed Income Fund<br>• Inflation-Linked Fixed Income Fund<br>• Large Cap Equity Index Fund<br>• Small/Mid Cap Equity Fund<br>• International Equity Fund<br>• Target Date Funds |
| **Eligibility for Retirement Benefit** | • Age 65 with 10 years of service.<br>• Age 60 with 15 years of service.<br>• At age 55 if age and creditable service total at least 85 ("Rule of 85").<br>• Early retirement with reduced benefits between ages 50-59 with 15 years of service.<br>• Age 65 with 20 years of service.[2]<br>• Special provisions for certain elected officials. | Automatic eligibility to withdraw DC balance once member separates from service.[3]<br>*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.<br>• Received a salary from a PERF-covered position within 30 days of the termination date.<br>• 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. |

[1] *Go to the PERF Hybrid Member Handbook for more on voluntary contributions.*
[2] *Actively 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.*
[3] *Certain restrictions may apply if the member is vested in a pension benefit.*

INPRS
INDIANA PUBLIC RETIREMENT SYSTEM

7/1/2024

# PERF HYBRID AT A GLANCE

PUBLIC EMPLOYEES' RETIREMENT FUND
HYBRID PLAN

| | 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:<br>• 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.<br><br>Members who are disabled or separated from service:<br>• may leave the DC account invested in INPRS or receive a distribution, or<br>• 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:<br>1. Age<br>2. Years of service<br>3. Average annual compensation (Final Average Salary) based on 20 quarters<br>4. Multiplier of 1.1 percent (.011)<br>• Benefit amount is taxable as ordinary income<br>• Survivor options are available<br><br>The monthly benefit amount is affected by the payment option election made at retirement.<br><br>Any Cost of Living Adjustment (COLA) must first be approved by the Indiana General Assembly. | Member chooses the form of payment.<br>• May choose monthly payment for the<br>• lifetime benefit<br>• May defer payment until RMD (required minimum distribution) age<br>May choose direct payment or rollover distribution<br><br>The amount of distribution is determined by account balance, taxes withheld, and distribution option chosen. |
| **Beneficiaries** | Monthly payment<br>• Following the death of a retired member under applicable payment options.<br>• Following the death of an active member based on eligibility. | **Balance payment**<br>• Receives the total accumulated amount after the death of an active member or retired member who elected to defer payment.<br>• 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 within60 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:



This benefit guide provides only a summary of your benefits. All services described within are subject to the definitions, limitations, and exclusions outlined in each insurance carrier's or provider's contract.

# 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 21, 2026
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


This benefit guide provides only a summary of your benefits. All services described within are subject to the definitions, limitations, and exclusions outlined in each insurance carrier's or provider's contract.

# 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 CO-BRA 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 privi-leges 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
DuringFMLA 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
Aserious health conditionisan 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 requireuse 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 30days 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
Coveredemployers 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
FMLAmakes it unlawfulfor anyemployer 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.**

# ***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 previous 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 | | 4. Employer Identification Number (EIN) |
|---|---|---|
| City of Fort Wayne | | 35-6001029 |
| 5. Employer address | | 6. Employer phone number |
| 200 East Berry | | 260-427-2634 |
| 7. City | 8. State | 9. ZIP code |
| Fort Wayne | IN | 46802 |
| 10. Who can we contact about employee health coverage at this job? | | |
| Laura Townsend | | |
| 11. Phone number (if different from above) | 12. Email address | |
| 260-427-2634 | 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 will guide you through the process. Here's the employer information you'll enter when you visit 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)






This benefit guide provides only a summary of your benefits. All services described within are subject to the definitions, limitations, and exclusions outlined in each insurance carrier's or provider's contract.