IGHCP

IOWA GOVERNMENTAL HEALTH CARE PLAN

Monona County

2024

BENEFITS GUIDE

HELPING YOU LIVE YOUR BEST LIFE

The right people. . .the right choice

ELIGIBILITY AND ENROLLMENT

BENEFIT ELIGIBILITY

If you're a full-time employee, you're eligible to enroll in the benefits outlined in this guide. Newly hired employees are eligible for benefits the first of the month following date of hire.

ELIGIBLE DEPENDENTS

- Your legal spouse
- A child under the age of 26 who is your or your spouse's natural child, stepchild, or legally adopted child; or a child for whom you or your spouse are legal guardian; or disabled dependent over age 26

If you enroll a spouse or child on a company health plan, you will need to attest in the Benefits Enrollment System that each dependent meets company eligibility rules. Before enrolling dependents, please ensure they meet the eligibility requirements above. If they don't qualify, coverage will be canceled, and you may be liable for the cost of any ineligible claims and premiums paid.

ELIGIBILITY AND ENROLLMENT

QUALIFYING LIFE EVENTS

Generally, you may only change your benefit elections during the annual open enrollment period. However, you may change your benefit elections during the year if you experience a qualifying life event, including:

- Marriage
- Divorce or legal separation
- Birth of your child (60 days)
- Death of your spouse or your child
- Change in employment status of the employee, spouse, or dependent child
- Qualification by the Plan Administrator of a child support order for medical coverage
- Loss of or Eligibility for Medicaid or CHIP coverage (60 days)
- For more details, see disclosures - Qualifying Events and HIPPA Special Enrollment.

You must notify the Auditor's Office within 30 days of the qualifying life event (60 days for loss of or eligibility for Medicaid or CHIP coverage or birth of your child).

You must submit the proper documentation supporting the life event when reporting the event itself. If you do not notify the Auditor's Office within the required timeframe, you will have to wait until the next open enrollment period to make changes (unless you experience another qualifying life event).

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ELIGIBILITY AND ENROLLMENT

NEW HIRE ENROLLMENTS

Newly hired employees are eligible to enroll in benefits the first of the month following date of hire

ANNUAL OPEN ENROLLMENT

Current employees are eligible to make changes or enroll in new benefits during our annual open enrollment period.

Annual open enrollment is the only time you can change current benefit selections unless you qualify for a special enrollment period.

Notify your Auditor's Office within 30 days of a qualifying life event to request a special enrollment. See federal laws and disclosures for more details on qualifying life events.

OPEN ENROLLMENT EFFECTIVE DATE

Make sure your ID card is easily accessible and available before you visit a provider.

After your plan goes into effect, be sure you provide your new ID card to your provider during your office visit.

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MEDICAL

For more information
Please refer to your plan documents.

Unless otherwise noted, benefits are per insured person and after deductible.

Plan name		Wellmark Blue Choice
Provider		Wellmark BCBS of Iowa
Network provider		Blue Choice
Benefit		**In-Network**
WELLMARK PLAN → Claims will process to these levels first		
Deductible	Individual	$5,000
	Family	$10,000
Out of Pocket Max	Individual	$7,350
	Family	$14,700
Coinsurance	In Network	70% / 30%
	Out of Network	60% / 40%
Emergency		Ded & Coins
EBS SELF-FUNDED → Claims will re-process to these levels		
Deductible	Individual	$750
	Family	$1,500
Out of Pocket Max	Individual	$3,000
	Family	$6,000
Coinsurance	In Network	80% / 20%
	Out of Network	80% / 20%
Emergency		$150 copay
PHYSICIAN SERVICES		
Preventative		Covered 100%
Primary Care Physician visit		$20 copay*
Specialist visit		$20 copay
Doctor on Demand		$0 copay
HOSPITAL MEDICAL SERVICES		
Inpatient Hospital		20% after deductible
Outpatient Surgery		20% after deductible
Urgent Care		$20 copay
Ambulance Services		20% after deductible
PRESCRIPTION DRUGS		
Tier 1 / Tier 2 / Tier 3 / Tier 4		$10 copay / $25 copay / $40 copay / $40 copay
Specialty		$85 copay**

*Members are eligible for a $5 discount when they see their designated PCP.
**Some specialty drugs are eligible for a $0 copay due to a partnership with PrudentRx. Members will be contacted directly if their medication is eligible.

This guide is subject to periodic review and modification. Each plan is governed by an official Summary Plan Description (SPD) document. If there is any conflict between this benefits guide and the SPD official document, the SPD plan document is the final authority. As an enrollee, your actual SPD will be provided under separate cover by your health carrier or your employer.

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FINANCIAL BENEFITS

FLEXIBLE SPENDING ACCOUNT (FSA)

Flexible Spending Accounts (FSAs) are designed to save you money on your taxes. They work in a similar way to a savings account. Each pay period, funds are deducted from your pay on a pre-tax basis and credited to a Health Care and/or Dependent Care FSA. You then use your funds in the applicable account to pay for eligible health care or dependent care expenses.

Plan year January 1, 2024 – December 31, 2024

The grace period to incur claims will be from January 1, 2025 – March 15, 2025. Claim filing deadline is March 30, 2025.

Healthcare Reimbursement FSA**

This program lets Iowa Governmental Health Care Plan employees pay for certain IRS-approved medical care expenses* not covered by their insurance plan with pre-tax dollars. Some examples include:	Annual Contribution Limits	Pre-Tax Benefits
• Deductibles, copays, and coinsurance • Hearing services, including hearing aids and batteries • Vision services, including contact lenses, contact lens solutions, eye exams, and eyeglasses. • Dental services and orthodontia • Doctor-prescribed prescription drugs and insulin are eligible • Maximum carryover amount: $640	Maximum contribution is $3,200	Saves on eligible expenses not covered by insurance

Dependent Care FSA

The dependent care FSA allows you to use pre-tax dollars towards qualified dependent care such as caring for children under age 13 or caring for elders.	Annual Contribution Limits	Pre-Tax Benefits
• The cost of child or adult dependent care • The cost for an individual to provide care either in or out of your house • Nursery schools and preschools (excluding kindergarten)	Maximum contribution is $5,000 per year ($2,500 if married and filing separate tax returns)	Reduces your taxable income

* You can obtain a complete list of eligible and ineligible expenses for FSAs at www.irs.gov. Search Forms and Publications (502 for health care plans and 503 for dependent care plans).

** Individuals enrolled in the Health Savings Accounts (HSA) Health Plan are not permitted to elect the Medical FSA.

EBS CLAIMS PORTAL

HOW TO ACCESS GATEWAY CLAIMS PORTAL

The EBS *Gateway Claims Po*rtal provides a more efficient method to access your claims information electronically and provides you with immediate access.

Easy steps for online access:

Go to **www.ebs-tpa.com** and click **Gateway Claims Login**

Returning users: Log in with the username and password you selected.

First-time users: Click here to register and/or enroll under the log in button.

1. Then choose the portal "Member."
2. Fill out the required information.
3. Create your unique username and password and submit.
4. An email will be sent to you to activate your account. Once activated, you can log in.

Technical Difficulties:

Already registered but forgot your username or password? If you have already registered for Gateway but you have forgotten your username and password? Please email gatewaysupport@ebs-tpa.com and we will assist you further.

What if my registration submission "Failed to Register" because "Member Information not Found"? Check that the formatting of the Date of Birth matches what is shown on the website. (Slashes instead of dashes and the full four numbers of the year.)

What if I did not receive the registration confirmation email with the link? Check your junk email or spam folder.

Why aren't EOB's opening? Check to make sure your browser is allowing pop-ups for this website.

Why can't I see claims for all of my family members? Due to HIPAA regulations, family members over the age of 18 have the right to privacy in terms of their claims information. Contact Gateway Support for assistance.

Help, I'm still having technical difficulties. Email gatewaysupport@ebs-tpa.com or call 800-373-1327 and ask for Gateway Support.

HOW TO SELECT YOUR PRIMARY CARE PROVIDER

What is a PCP?

A primary care provider (PCP) is a health care practitioner who sees people that have common medical problems. A PCP is your main health care provider in non-emergency situations. Their role is to:

- Provide preventive care and teach healthy lifestyle choices
- Identify and treat common medical conditions
- Assess the urgency of your medical problems and direct you to the best place for that care
- Make referrals to medical or surgical specialists when necessary

You can choose from several different types of PCP's:

- Family practitioners
- Pediatricians
- Geriatricians
- Internists
- Obstetricians/gynecologists
- Nurse practitioners (NP) and physician assistants (PA)

Establishing an ongoing relationship with a Primary Care Provider (PCP) is an important part of health and wellness. As such, Wellmark will be offering a $5 discount on applicable office visit copays when you see your designated PCP. While designating a PCP is not required, you will receive an automatic discount on your copay at the time of service.

If you do not designate a PCP, the Wellmark system will analyze your claims history and will automatically assign you one. You can change your assigned PCP any time by logging into myWellmark or calling Wellmark Customer Service.

How to designate a PCP:

- Log in to your myWellmark account
- Call Wellmark Customer Service at 800.591.3873
- List your PCP on your enrollment form

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DOCTOR ON DEMAND

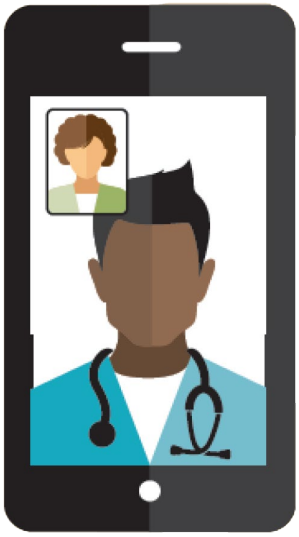
Wellmark

FEELING BETTER SHOULD BE EASY.

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

See a doctor in minutes.

Getting sick is bad enough without having to get out of bed, go to the doctor, and sit in a waiting room with other sick people. With Doctor on Demand, you and your family members can see a board-certified doctor in minutes who can treat the most common medical conditions and prescribe medication if needed [1].



Questions? Call 800-977-6196.

Get treatment for:

- **Cold and flu**
- **Bronchitis and sinus infections**
- **Urinary tract infections**
- **Sore throats**
- **Allergies**
- **Fever**
- **Headache**
- **Pink eye**
- **Skin condition**
- **Mental health issues** (including anxiety, depression, relationship issues, grief, eating disorders, smoking cessation or alcohol dependence)[2]

Dr DOCTOR ON DEMAND

Getting Started Is Easy.

1. **Download the Doctor on Demand app or visit DoctorOnDemand.com**
2. **Have your Wellmark member ID card ready.**
3. **Create an account or sign in.**

[1] Doctor On Demand physicians do not prescribe Schedule I-IV DEA Controlled Substances and may elect not to treat or prescribe other medications based on what is clinically appropriate.)

[2] Services performed by psychologists are available for some plans. Psychiatry is not covered. For more information, ask your benefits administrator or call Wellmark at the number on your ID card.

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PRESCRIPTION DRUG INFORMATION

Blue RX CompleteSM
www.wellmark.com

Welcome

We cover both brand-name drugs and generic drugs. Generic drugs have the same active-ingredient formula as brand-name drugs. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand-name drugs. Members may be required to pay more for a prescription when a brand-name product is dispensed.

What is a Drug List?

A formulary drug list is a list of drugs covered under your pharmacy benefit and developed to serve as a guide for physicians, pharmacists, healthcare professionals, and members in the selection of cost-effective drug therapy. The formulary does not define benefit coverage and limitations. Many members have specific benefits inclusions, exclusions, copayments, or lack of coverage, which are not reflected in the formulary. Members should contact their plan sponsor or Wellmark Customer Service at the number on the back of their ID card if they have questions regarding their coverage.

	Tier Designation			
Blue RX	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 4**
Complete 4 Tier	Tier 1	Tier 2	Tier 3	Tier 4
Complete 3 Tier	Tier 1	Tier 2	Tier 3, and Tier 4 combined	
Complete 2 Tier	Tier 1	Tier 2, Tier 3, and Tier 4 combined		
Complete 1 Tier	Tier 1, Tier 2, Tier 3, and Tier 4 combined			

Formulary Exception Process

Drugs not included in this list shall be considered non-formulary and are NOT COVERED. In some instances, Wellmark will consider coverage expectations. Coverage of non-formulary drugs may be requested by the health professional through an expectation request for a non-formulary prescription drug. Generally, the following guidelines must be documented in order for an exception to be granted.

- All covered formulary drugs on any tier will be ineffective;
- Or All covered formulary drugs on any tier have been ineffective;
- Or All covered formulary drugs on any tier would not be as effective as the non-formulary drug;
- Or All covered formulary drugs on any tier would have adverse effects

How to Search For Drugs?

- Use the alphabetical list to search by the first letter of your medication.
- Search by typing part of the generic and brand names
- Search by selecting the therapeutic class or category of the medication you are looking for.

Common Drug Exclusions

Due to benefit design parameters, some plan sponsors may exclude certain drug classes. Prior authorization is generally not available for drugs that are specifically excluded by benefit design. Common excluded drugs may include, but not limited to:

- OTC Drugs or equivalents unless specified in the formulary listing.
- Drug products used for cosmetic purposes
- Experimental drug products, or any drug product used in an experimental manner
- Replacement of a lost or stolen drug
- Foreign drugs or drugs not approved by the United States Food & Drug Administration (FDA)

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DENTAL

Dental Insurance

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems.

Dental benefit runs on a calendar year basis
(January 1 – December 31)

Administered by Delta Dental

	Delta Dental of Iowa	
Benefit	**PPO**	**Premier / Non-Participating**
Annual Maximum Per Individual / Per Benefit Year	$2,000	$2,000
Calendar Year Deductible (CYD) Single / Family	$25 / $75	$50 / $150
Diagnostic and Preventive[1]	100%, Ded waived	100%, Ded waived
Routine and Restorative[2]	70%, Ded applies	60%, Ded applies
Endodontic Services[3]	60%, Ded applies	60%, Ded applies
Periodontal Services Conservative/complex procedures Maintenance Therapy	60%, Ded applies	60%, Ded applies
Cast Restorations[4]	60%, Ded applies	60%, Ded applies
Prosthetics[5]	60%, Ded applies	60%, Ded applies
Orthodontia Services (under age 19 only)	Not Covered	Not Covered
Orthodontia Lifetime Maximum (per individual)	Not Covered	Not Covered

[1]Includes checkups, cleanings, Fluoride applications, bite-wing x-rays
[2]Includes emergency treatment, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery
[3]Includes Pulpotomy, root canal therapy
[4]Includes crowns, inlays, and overlays
[5]Includes dentures and bridges. Implants NOT covered.

This is a general description of coverage. Actual coverage is subject to terms and conditions specified in the certificate of coverage and enrollment regulations in force when the certificate becomes effective. Certain exclusions and limitations apply.

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VISION

Voluntary Vision Insurance

Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone.

Vision benefit runs on a calendar year basis (January 1 – December 31)

Administered by Delta

	Delta Vision	
Benefit	**In-Network**	**Out-of-Network**
Eye Exams (Once every calendar year)	$10 copay	Up to $35
Prescription Glasses		
Standard Lenses	$15 copay	Up to $25 through $55
Lens – Standard Progressive	$75 copay	Up to $40
Lens – Specialty	$95 / $105 / $120 / $120 allowance + 20% off the balance + $75 copay	Up to $40
Frames (Once every two calendar years)	$150 allowance + 20% off the balance	Up to $75
Lens Options:		
Standard Polycarbonate	$40 copay	N/A
Standard Plastic Scratch Coating / Tint / UV Treatment	$15 copay	N/A
Standard Anti-reflective Coating	$45 copay	N/A
Contacts (Once every calendar year)		
Conventional	$150 allowance + 15% off the balance	Up to $120
Disposable	$150 allowance	Up to $120
Medically Necessary	$0	Up to $200
Lasik Surgery	85% of Retail Price or 95% of Promotional Price	N/A

This is a general description of coverage. Actual coverage is subject to terms and conditions specified in the certificate of coverage and enrollment regulations in force when the certificate becomes effective. Certain exclusions and limitations apply.

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YOUR BENEFIT COST

The chart below displays the monthly contributions you would make for your choice of medical, dental, and/or vision plans. Your total contribution is automatically made through payroll deductions once you have made your elections.

MEDICAL MONTHLY COST SHARE

	Total Monthly Premium	Employer Cost	Employee Cost
WELLMARK BLUE CHOICE			
Employee	$1,203.52	$1,203.52	$0
Employee / Spouse	$2,660.78	$2,235.06	$425.72
Employee / Child(ren)	$2,146.78	$1,803.30	$343.48
Family	$2,786.78	$2,340.90	$445.88

DENTAL PAYROLL DEDUCTIONS

	Employee Cost
DELTA DENTAL	
Employee	$32.76
Employee + 1	$64.16
Family	$109.98

VISION PAYROLL DEDUCTIONS

	Employee Cost
DELTA VISION	
Employee	$5.40
Family	$13.88

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EMPLOYEE ASSISTANCE PROGRAM

Easy Access and First-Person Connections

The Standard's Uncommon Approach to EAP Services

The Standard
standard.com

For employees, asking for help can feel hard and scary, especially during uncertain times. Standard Insurance Company (The Standard) makes it easy with the Employee Assistance Program (EAP) in connection with our Group Long Term Disability.

Take advantage of our EAP services to enjoy enhanced quality and support in five key ways:

1. **Multiple access points make connecting easy.**

   To make EAP services easily accessible and add value for all generations in the workforce, employees can contact counselors 24/7 by phone, online, live chat, email, and text. **There's even a mobile EAP app**. Assistance is immediate and personal, with no hand-offs.

2. **Continuity of care leads to high satisfaction.**

   Employees using EAP services work with a master's-level counselor throughout the assessment, referral, and follow-up process, ensuring continuity of care.

3. **Clinical phone consultations build relationships.**

   Clinical phone consultations build relationships. Our philosophy differs from a traditional call center that may simply provide a referral. Care managers develop a relationship with the EAP member by identifying the reason for the call, providing immediate support, making referrals, and screening for any risk concerns. They also educate the EAP members about the benefits offered through the EAP Program.

4. **Referrals to counseling sessions are simple and stress-free.**

   Prior to providing a referral, the care manager identifies if the EAP member would like face-to-face or virtual counseling. If face-to-face is preferred, the care manager will call the affiliate counseling, and the care manager will confirm the member has access and assist them with signing up for counseling.

5. **Case management supports specialized referrals.**

   Case management supports specialized referrals. When EAP members need specialized services, the care manager empowers the member by educating them about available resources and helping with referral options.

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EMPLOYEE ASSISTANCE PROGRAM

The Standard's Enhanced EAP Services At-A-Glance

Service Feature	Highlights
Multiple Access Points	Employees have 24/7 direct access to master's level counselors, including • Phone/text/email • Website • Mobile App
Clinical Services	Telephone assessment and referral using evidence-based evaluation tools for: • Addictions • Depression, anxiety, and stress • Relationships and parenting • Up to three or six short-term problem-resolution sessions per presenting problem per year (distance sessions available by phone or video)
Case Management	Coordinated telephone intake, case management and follow up by a master's-level counselor ensures continuity of care.
Clinical Referrals	Referrals are provided to experienced, licensed/credentialed counselors in the employee's community.
WorkLife Services	• Legal and financial questions • Identity theft resolution services • Childcare, elder care, adoption, and education
Online and Mobile Resources	• Employee website: articles, self-search locators, financial calculators, online legal documents, health assessments, and more. • HR and People leader information available online • Mobile application: on-the-go information and access to EAP services. The app is available free on IOS and Android. Search HealthJoy or scan QR Code.
Management Consultation Services	Consultation on troubled employees in the workplace and case management support following a referral to the program.
Utilization Reports	Electronic utilization reports are available by request
Communication materials	Print and online resources include EAP brochure, poster, monthly emails, monthly live webinars, and manager email pushes
Critical Incident Stress management services	Unlimited telephonic support Ten hours of on-site crisis support, per incident, in the event of a catastrophic workplace incident affecting a group of employees (e.g., robbery, assault, employee injury or death in the workplace)
Additional On-Site Services	Available on a fee-for-service basis

Standard Insurance Company | 1100 SW Sixth Avenue, Portland, OR | standard.com

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INCOME PROTECTION

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

Monona County provides you with Basic Life and AD&D coverage for all eligible employees at no charge. The benefit level is equal to $15,000.

VOLUNTARY LIFE INSURANCE

If you would like additional life insurance, you can purchase voluntary life and AD&D insurance for you, a spouse, and your eligible children through Standard Insurance Company. Evidence of Insurability (EOI) is not required up to the guaranteed issue amount. Your contribution for this additional benefit will be deducted post-tax from your paycheck. View the chart to the right for monthly voluntary employee and spouse rates per $1,000 of benefit.

A single-child life policy covers all eligible children up to age 25. Voluntary child life insurance is $2.00 per month for $10,000 and $1.00 per month for $5,000.

MONTHLY VOLUNTARY LIFE CONTRIBUTIONS

Age (as of July 1)	EMPLOYEE Cost per $1,000 of coverage	SPOUSE Cost per $1,000 of coverage
<35	$0.11	$0.08
35-39	$0.14	$0.11
40-44	$0.21	$0.18
45-49	$0.29	$0.26
50-54	$0.48	$0.45
55-59	$0.78	$0.75
60-64	$1.21	$1.18
65-69	$1.90	$1.87
70-74	$2.99	$2.96
75>	$5.29	$5.26

Note: Spouse rate is based on Employee age. Includes a monthly AD&D rate of $0.03 per $1,000 of AD&D benefit for the Employee.

Plan	Coverage	Guaranteed Issue *(Amount allowed without proof of good health)*
Voluntary Employee Life and AD&D	Choice of 10,000 increments Not to exceed five times your annual salary Max amount $500,000	$200,000 At initial enrollment
Spouse Life and AD&D	Choice of $5,000 increments Not to exceed 50% of employee elected amount Max amount $250,000	$40,000 At initial enrollment
Child(ren) Life and AD&D	A flat amount of $5,000 or $10,000 Employee must enroll to enroll child(ren) Max amount $10,000	N/A

Note: Dependent life insurance cannot exceed 50% of employee voluntary life coverage. You must elect voluntary life insurance to be able to request it for your spouse or dependent. If you do not enroll when first eligible you will be subject to medical questions, and underwriting. Also, if you choose coverage that is higher than the guaranteed amounts, it will be subject to evidence of insurability.

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INCOME PROTECTION

VOLUNTARY LIFE AND AD&D INSURANCE

What does this mean to you?

NEW HIRES ONLY

During the initial Enrollment, all full-time employees are eligible for Guarantee Issue life insurance regardless of your health or prior applications; each new hire is eligible to receive up to $200,000 of term life insurance Up to $200,000 guaranteed regardless of health underwriting required on any amount over $200,000

During the initial Enrollment, Spouses are eligible for Guarantee Issue life insurance regardless of your health or prior applications; each spouse is eligible to receive up to $40,000 of term life insurance Up to $40,000 Guaranteed regardless of health. Underwriting required on any amount over $40,000

During the initial Enrollment, Children are eligible for Guarantee Issue life insurance regardless of your health or prior applications; each child is eligible to receive up to $5,000 or $10,000 of term life insurance.

ACTIVE ELIGIBLE EMPLOYEES AT OPEN ENROLLMENT

If you enrolled in the program at the initial offering, Employees can elect up to an additional $20,000 per year to Guarantee Issue (not to exceed $200,000 in total). Spouses can elect up to an additional $10,000 per year to Guarantee Issue (not to exceed $40,000 in total)

If you do not participate in the initial offer, you are eligible to enroll in one or two increments of $10,000 during the Annual Enrollment Period. Your Spouse is eligible to enroll in one or two increments of $5,000 during the Open Enrollment Period as well.

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INCOME PROTECTION

For more information
Contact an Insurance Advisor or
The Standard at 800-633-8575

LINE OF DUTY BENEFIT

Helping Protect Those Who Protect and Serve

On a daily basis, firefighters and police officers put their lives on the line to keep our homes and communities safe and secure. To help protect them and their families from a financial loss after a covered line of duty accident, Standard Insurance Company (The Standard) offers an optional Line of Duty Benefit to public employer groups with Group Life and AD&D insurance, who cover employees meeting the group policy's definition of a public safety officer.

This optional benefit provides public safety officers an additional $50,000 or 100 percent of the AD&D insurance benefit, whichever is less when suffering a loss for which an AD&D insurance benefit is payable, and which is the result of a line of duty accident.

Public safety officers include police officers, firefighters, corrections officers, judicial officers and officially recognized or designated volunteer firefighters meeting the definition of a public safety officer.

IN THE LINE OF DUTY: THE STORIES BEHIND THE NUMBERS

Two Examples of how the Line of Duty Benefits can help:

While on duty, a firefighter insured for $100,000 of Life and AD&D insurance coverage responds to a building fire. A gas leak occurs, causing an explosion that results in the firefighter's death. In this example, the firefighter's beneficiaries may be eligible to receive the following: Life benefit of $100,000 and AD&D benefit of $100,000, plus a $50,000 Line of Duty Benefit for a total payment of $250,000.

While on duty, a police officer insured for $100,000 of Life and AD&D insurance coverage is involved in a high-speed chase that ends in a collision, resulting in the loss of sight in one of his eyes. In this example, the police officer may be eligible to receive the following: An AD&D benefit of $50,000, as the policy pays 50 percent of the AD&D benefit for loss of the sight of one eye, plus a $50,000 Line of Duty Benefit for a total payment of $100,000.

With the Line of Duty Benefit from The Standard, public employer groups can help provide financial protection to public safety officers who have dedicated their lives to protect and serve.

Note: The examples above are hypothetical and are used for illustrative purposes only. This policy has exclusions, limitations, reduction of benefits, and terms under which the policy may be continued in force or terminated. Please contact The Standard for additional information, including costs and complete details of coverage.

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SAFE, SECURE AND PROTECTED

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

Priceless peace of mind

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

With IDX Identity, you can:

Monitor your credit record.

Keep track of your online activity 24 hours a day, seven days a week.

Have access to complete identity recovery if fraudulent activity is found.

Enroll in identity protection services today!

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

1. Select Identity Protection under Do More and click the Enroll/Log in link.

2. Select Enroll Now from the home page.

3. Fill out the Group ID and Subscriber ID (also known as your Wellmark ID number). Both are found on your Wellmark ID card.

4. Enter your personal information and create a username and password.

5. To activate credit monitoring, enter your birth date and Social Security number.

Rather enroll over the phone?

JUST CALL 866-486-4812 and make sure you have your Wellmark ID card handy.

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

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

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

BeWell 24/7℠ — get connected with a real person who can help you with a variety of health-related concerns. Just call **844-84-BEWELL (239355).**

Blue365® — find exclusive ways to save on top wellness services and products you use every day.

Blue℠ — simply visit Wellmark.com/Blue to stay informed on health plan updates and the latest in health and wellness.

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

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

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

Wellmark

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KEY TERMS TO KNOW

Brand-Name Drugs: Drugs that have trade names and are protected by patents. Brand-name drugs are generally the costliest choice.

Coinsurance: The percentage of a covered charge paid by the plan.

Copayment (Copay): A flat dollar amount you pay for medical or prescription drug services regardless of the actual amount charged by your doctor or health care provider.

Deductible: The annual amount you and your family must pay each year before the plan pays benefits.

Generic Drugs: Generic drugs are less expensive versions of brand-name drugs that have the same intended use, dosage, effects, risks, safety, and strength. The strength and purity of generic medications are strictly regulated by the Federal Food and Drug Administration.

High Deductible Health Plan: A health plan with a high deductible used in conjunction with a health reimbursement account (HRA) or a health savings account (HSA).

Health Reimbursement Account (HRA): A fund you can use to help pay for eligible medical costs not covered by your medical plan. Funds are contributed to the HRA by your employer.

Health Savings Account (HSA): A fund you can use to help pay for eligible medical costs not covered by your medical plan. Both employers and employees may contribute to this fund; employees do so through pre-tax payroll deductions.

In-Network: Use of a health care provider that participates in the plan's network. When you use providers in the network, you lower your out-of-pocket expenses because the plan pays a higher percentage of covered expenses.

Inpatient: Services provided to an individual during an overnight hospital stay.

Mail-Order Pharmacy: Mail-order pharmacies generally provide a 90-day supply of prescription medication for the same cost as a 60-day supply at a retail pharmacy, and they offer the convenience of shipping directly to your door.

Out-of-Network: Use of a health care provider that does not participate in the plan's network.

Out-of-Pocket Maximum: The maximum amount you and your family pay for eligible expenses each plan year. Once your expenses reach the out-of-pocket maximum, the plan pays 100% of eligible expenses for the remainder of the year.

Outpatient: Services provided to an individual at a hospital facility without an overnight hospital stay.

Primary Care Physician (PCP): A physician (generally a family practitioner, internist or pediatrician) who provides ongoing medical care. A primary care physician treats a wide variety of health-related conditions and refers patients to specialists, as necessary.

Specialist: A physician with specialized training in a particular branch of medicine (e.g., a surgeon, gastroenterologist, or neurologist).

CONTACTS

IGHCP Contacts		
Regan Jones Claims / Customer Service	319-758-8423	rjones@ighcp.com
Dani Bredar Claims / Customer Service	319-758-8429	dbredar@ighcp.com
Marla Jones Claims / Customer Service	319-753-0144	mjones@ighcp.com
Jennifer McMillan Group Liaison	319-758-8419	jmcmillan@ighcp.com
Denise Ballard Consultant	319-758-8408	dballard@ighcp.com

DISCLOSURES

The following pages outline plan disclosures and additional information, including your rights.

MEDICARE PART-D

Important Notice About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Prescription drug coverage offered by the Wellmark BCBS of Iowa is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered **Creditable Coverage**. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

For more information about Medicare prescription drug coverage:

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

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

SECTION 125

Under certain circumstances, you may be allowed to make changes to your benefits elections during the plan year, such as additions, deletions and cancellations, depending on whether or not you experience an eligible qualifying event as determined by the Internal Revenue Service (IRS) Code, Section 125. You may change a benefit election upon the occurrence of a valid qualifying event only if the event affects your own, your spouse or your dependent's coverage eligibility.

If you experience a qualifying event, you must report the qualifying event to Human Resources Department within 30 days of the event. Beyond 30 days, additions and deletions will be denied and you may be responsible both legally and financially for any claims and/or expenses incurred as a result of any dependent(s) who continued to be enrolled who no longer meet the entity's eligibility requirements.

If approved, most election changes will be effective on the date of the qualifying event for additions; cancellations will be processed at the end of the month.

Payroll deductions for health, dental, vision and certain supplemental accident insurance premiums, are deducted from your gross income before your income is taxed. The entity's plan is known as a Cafeteria Benefit Plan and is governed by IRS Code, Section 125. This pre-tax benefit means you pay less tax on a per-pay and annual basis.

See examples of Qualifying Life Events for allowable enrollment changes as determined by Section 125 of the IRS Code.

QUALIFYING EVENTS:

- Change is status (for example, employee's legal marital status, number of dependents, employment status, dependent eligibility change, change in residence, or adoption proceedings);
- Significant cost changes
- Significant curtailment of coverage
- Change in coverage under other employer's plan
- Addition or significant improvement of benefit package option
- FMLA leaves of absence
- Loss of group health coverage sponsored by a governmental or educational institution
- COBRA qualifying events
- HIPAA special enrollment events
- Judgement, decree, or court order, such as Qualified Medical Child Support Order (QMCSO)
- Medicare or Medicaid enrollment

HIPAA SPECIAL ENROLLMENT NOTICE

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

LOSS OF OTHER COVERAGE

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

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

MARRIAGE, BIRTH OR ADOPTION

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

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

MEDICAID OR CHIP

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

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

For More Information or Assistance

To request special enrollment or obtain more information, please contact your Human Resources department.

NMHPA | WHCRA

NEWBORNS' AND MOTHER'S HEALTH PROTECTION ACT

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT *Enrollment Notice*

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

All stages of reconstruction of the breast on which the mastectomy was performed;

Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

Wellmark BCBS of Iowa	Wellmark Blue Choice
Individual	$750
Family	$1,500
Co-insurance	80% / 20%

If you would like more information on WHCRA benefits, call your plan administrator.

WOMEN'S HEALTH AND CANCER RIGHTS ACT *Annual Notice*

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

PREMIUM ASSISTANCE UNDER MEDICAID/CHIP

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

If you live in one of the participating states, you may be eligible for assistance paying your employer health plan premiums. Follow the link below for a complete list of contact information by state.

Please visit https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/chipra/model-notice.pdf

COBRA CONTINUATION COVERAGE RIGHTS

INTRODUCTION

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

WHEN IS COBRA COVERAGE AVAILABLE?

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

Qualifying Events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).
- *If the plan has retirement coverage:* Commencement of a proceeding in bankruptcy with respect to the employer

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

Keep your plan informed of address changes.

COBRA CONTINUATION COVERAGE RIGHTS

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

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

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

The month after your employment ends; or the month after group health plan coverage based on current employment ends.

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

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

Questions concerning your Plan, or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below.

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website).

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

Keep your Plan informed of address changes

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

NOTES

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IOWA GOVERNMENTAL
HEALTH CARE PLAN

IGHCP
Iowa Governmental Health Care Plan
214 N. Main Street, Burlington, IA 52601 | Phone: 319-753-0144
www.IGHCP.com

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