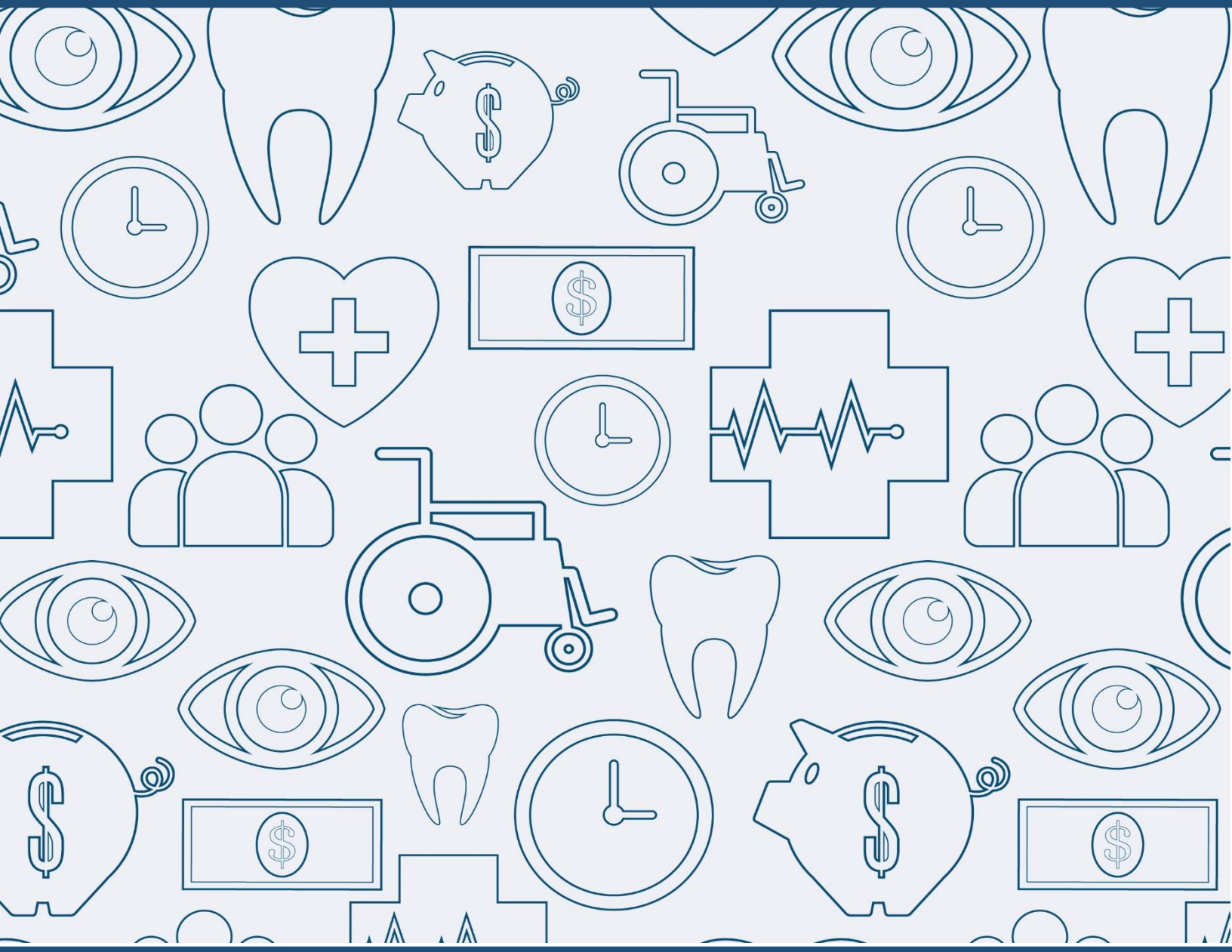
THE VILLAGE OF
SWANTON

2024 Enrollment/Benefits Guide



PICKING THE BEST BENEFITS…
FOR YOU AND YOUR FAMILY

VILLAGE OF SWANTON strives to provide you and your family with a comprehensive and valuable benefits package. We want to make sure you are getting the most out of our benefits—that's why we've put together this Benefits Guide.

This booklet is intended to be utilized during Open Enrollment and when initially hired. Open Enrollment is a short period of time before your groups renewal date that allows you to alter or change your benefit elections. This guide will outline all of the different benefit options available, so that you can identify which offerings are best for you and your family.

If you have questions about any of the benefits mentioned in this guide, please contact your HR representative.

This guide is intended for informational purposes only.

Eligibility

Who is Eligible for Benefits?

If you are a full-time employee (working 30 or more hours per week) you and your family members are eligible to enroll in the benefits described in this guide.

When Should I Enroll? Initial Enrollment / Open Enrollment

New employees become eligible on the first of the month following 30 days from their date of full time hire for Medical coverage. Eligible employees are defined as full-time or, regularly scheduled to work 30 hours/week or more. Refer to Employee Handbook 7(A). Additionally, if you work 40 or more hours per week you are also eligible for Voluntary Dental and Vision coverage. Open Enrollment is the month of December for Medical, Dental and Vision coverage. The benefits you elect during open enrollment will be effective January 1st. Outside of open enrollment, you may come onto the plan only if you have a qualifying event.

How do I Enroll?

Review your current benefit offerings within your new hire packet, open enrollment packet, or this Benefits Guide. Once you have made your elections, you will not be able to change them until the next open enrollment period unless you have a qualified change in status.

How do I Make Changes? What is a Qualifying Event?

Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period. Qualified changes in status include: death, marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, change in residence due to an employment transfer for you, your spouse, commencement or termination of adoption proceedings, or change in spouse's benefits or employment status.

Qualified Life Events for Status Change:

Marriage: You are required to report a marriage to your employer, within 31 days. A copy of the marriage license and insurance company applications are required to change your name, beneficiary, address, or to add or delete dependents from the benefit plans. If your new spouse is eligible for group health coverage through their employer, they may not be eligible to enroll under your policy.

Birth/Adoption: You are required to add a new child, either by adoption or by natural birth, within 31 days from the date of birth or acquisition. A copy of the Birth Certificate or Court document is required.

Court Orders: If you are enrolling a dependent child(ren), whose coverage might be governed by a divorce decree, or other support order, please look at your documents carefully. Depending upon how your divorce or court order was written, the dependent may NOT be eligible for this plan. *If your court order specifies that the other parent is responsible for health insurance coverage* (or payment of health care claims if there is no insurance), *then this plan might not cover your child(ren)*. A copy of the court documents or Medical Support Notice is required to enroll a dependent child(ren).

Different last name for spouse or children: Insurance companies or your employer may require proof such as marriage license, birth certificate, court document, or recent tax form, to show that dependents with different last names are your legal dependents. Enrollment or payment of claims may be pended until proof is received. Please be prepared to submit this documentation if requested by the carrier or your employer. Your dependent may not be enrolled if documentation is not received when requested.

Divorce or Legal Separation: If you become legally separated or divorced, it is required that you submit a copy of the appropriate finalized court papers within 31 days of the event in order to make any changes to your plan elections. You may be unable to change your plan elections without this documentation.

Spousal Waiver Policy

If your spouse is eligible for group health insurance through his or her employer, then he or she will not be eligible to obtain coverage under the Village of Swanton, group health plan. Spousal waiver form is required.

Below is an overview of the current plan designs with Medical Mutual of Ohio. Participating providers and hospitals for all plans can be found at www.medmutual.com. The network is Super Med Plus.

Please note: Your dependent children are eligible to be on this plan until they reach the age of 26.

Medical Plan Design	MMO 30-2000 Rx Option 1	MMO HSA 5000 PD Rx Option 2
Deductible (Single / Family)	$2,000 / $6,000	$5,000 / $10,000
Coinsurance %, Including Inpatient / Outpatient	0% After Deductible	0% After Deductible
Out-Of-Pocket Maximum (Single / Family)	$6,600 / $13,200	$6,900 / $13,800
Office Visit Co-Pay (PCP / Specialist)	$30 / $60	0% After Deductible
Preventative Services	Paid at 100%	Paid at 100%
Prescription Drug (Tier 1 / 2 / 3/ 4)	$10/$50/$125/$300	$15/$45/$75/$275 After Deductible
Emergency Room / Urgent Care Co-Pay	$300+Deductible / $75	0% After Deductible

The plan overview is displaying benefits for services rendered In-Network. Please review the full SBC (Summary of Benefits and Coverages) for a full explanation of benefits. (*Your benefit deductibles reset every January 1st*.)

Your Cost for 2024

The Employee Bi-Weekly Cost Share at 10% is illustrated below for Employee and Dependents cost.

Employee Cost Share	Single	Employee & Spouse	Employee & Child(ren)	Family
Option 1	$27.91	$61.40	$50.24	$83.73
Option 2	$18.00	$39.27	$32.18	$53.46

Health Savings Account (HSA) – Option 2

- Used in conjunction with high-deductible health plan Option 2
- Allows for pre-tax contribution through payroll deduction
- An HSA account can be opened using Farmers and Merchants State Bank
- Allows employees to pay certain IRS-approved out of pocket medical care expenses such as co-pays and deductibles with pre-tax dollars. Unspent dollars are rolled over each year.
  - 2024 HSA maximum contributions are: Single $4,150, Family $8,300
  - Village of Swanton will provide a $50 per month contribution for each employee who has elected Option 2
- If you are age 55 or older, you may contribute an additional $1,000 as a catch up provision
- A complete list of qualified medical expenses can be found at www.irs.gov

Medical Plan: Eligible employees will be offered a medical plan that has been adopted by action of the Village Council. Eligible employees choosing to be a part of the plan will pay 10% of the annual medical/health insurance premium. The 10% employee contribution will be deducted from employee payroll checks.

Dental/Optical Health Plan: The Village shall reimburse full-time employees, not enrolled in an HSA medical plan, for dental/optical expenses the employee, spouse and each dependent child of the employee incurs, in the cumulative total of $500.00 per calendar year per employee. Any unused funds for the calendar year shall not carry over to the next year. Employee shall submit the bill and voucher along with a completed Dental and Vision Reimbursement Form to their Division Head. After the Division Head has verified the claim, it shall be submitted to the Finance Director for payment. Payment shall be made directly to the employee. Employees have 6 months from the date of service or 4 months after the end of the plan year, whichever is earlier, to deliver the bill and voucher to the Village. Failure to do so will terminate the employee's right to reimbursement. Reimbursement is not available to those employees electing an HSA plan effective January 1st, 2024.

Prescription Plan: For the most current information reference the 2024 personnel handbook.

Dental (Voluntary) Insurance – The Principal Group

In addition to protecting your smile, dental insurance helps pay for dental care and usually includes regular checkups, cleanings and X-rays. Several studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body—including your heart. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.

The following chart outlines the dental benefits we offer.

- *Available for employees who work 40 or more hours per week*
- Employee pays the full cost of this coverage
- Maximum Accumulation Benefit included, $1,000 max available
- This plan allows you the freedom to seek services in and out of network
- Participating providers can be found on Principal.com Network: *Principal Plan PPO*

Dental Plan Design	Principal
Deductible (Single / Family)	$50 / $150
Preventative Services (Exam, Cleaning, X-Rays)	100%
Basic Services (Fillings , Extractions, etc.)	20%
Major Services (Root Canal, Oral Surgery, Crowns)	50%
Annual Maximum Benefit (Per Person)	$1,000
Orthodontia Services (Children to age 19) (Per Child Lifetime Max.)	50% $1,000

Employee Cost Share	Single	Employee & Spouse	Employee & Child(ren)	Family
Bi-Weekly	$14.16	$29.46	$40.22	$58.63

Vision Insurance (Voluntary) – The Principal Group

Driving to work, reading a news article and watching TV are all activities you likely perform every day. Your ability to do all of these activities, though, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems.

Vision insurance entitles you to specific eye care benefits. Our policy covers routine eye exams and other procedures, and provides specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses.

If you seek the services of a provider listed in our Preferred Provider directory, your benefits include the following:

- *Available for employees who work 40 or more hours per week*
- Employee pays the full cost of this coverage
- This plan allows you the freedom to seek services in and out of the network
- Participating providers can be found on VSP.com using the *Choice Network*

Vision Plan Design	Principal
Annual Eye Exam	$10 Co-Pay
Annual Lenses	$25 Co-Pay
Frame (Every 24 Months)	$25 Co-Pay
Frame Benefit (20% Off Amount Over Allowance)	$150 Allowance
Contact Lenses (Medically Necessary in lieu of Frames / Lenses)	$25 Co-Pay
Contact Lenses (Elective – for Fitting and Evaluation)	Up to $60; $150 allowance

Employee Cost Share	Single	Employee & Spouse	Employee & Child(ren)	Family
Bi-Weekly	$3.24	$6.74	$7.05	$11.30

Short Term Disability - Mutual of Omaha

- Employer pays the full cost of this coverage
- Eligible employees must work a minimum of 40 hours per week
- Pays in the event you become disabled from a non-work related injury or sickness

Short Term Disability	Mutual of Omaha
Benefits Begin	0 Day Accident 8 Day Sickness
Benefits Payable	Up to 26 Weeks
Weekly Maximum Benefit	$200

Basic Life Insurance - Mutual of Omaha

- Employer pays the full cost of this coverage
- Full-time employees working 40 hours per week receive a benefit of $50,000 group life and accidental death and dismemberment (AD&D) insurance

Employer Provided Group Term Life AD&D	Mutual of Omaha
For All Eligible Employees	$50,000

Holiday Pay

- Employer pays for the following days:
- New Year's Day, Martin Luther King Day, Presidents' Day, Memorial Day, Independence Day, Labor Day, Columbus Day, Thanksgiving Day, Day after Thanksgiving, Christmas Eve, Christmas Day, New Year's Eve, Juneteenth, "floating birthday".

Additional Resources

Talk to a doctor anytime. Board Certified doctors available 24/7/365 to resolve your medical issues through phone or video consults. Prescriptions sent to your pharmacy of choice. To avoid costly out of pocket expenses at the Emergency Room or Urgent Care, contact your telemedicine provider. Your responsibility/copay for this visit for Option 1 is $0, and Option 2 is $49. You can use your HSA funds to pay for this visit.

Can they write me a prescription?
Yes, if medically appropriate, and allowed in your state. Prescription writing is at the healthcare provider's discretion. A consultation is not a guarantee of prescription.

How much does it cost? Is it covered by insurance?
Some insurance companies cover telehealth sessions like a regular office visit. If your insurance company doesn't currently cover telehealth, you can still use the service. The cost of a Express Care Online visit is $49 for a 10-minute consultation. The cost of specialty services can be discussed with your provider in-person.

For more information about Express Care Online or to watch a demonstration video, please visit ClevelandClinicExpressCare.org/Online

Cleveland Clinic

Cleveland Clinic

Express Care **Online**

24/7 care you need right now, from home – or anywhere via your smartphone, tablet or computer.

What is Express Care Online?
Online medical care is medicine built for the way you live today. It's a simple, affordable service that lets you see a caregiver whenever, however, wherever you want to, online or by mobile app. Once you're connected, your healthcare provider can review your history, answer your questions and at their discretion diagnose, treat and even prescribe medication. If you receive a prescription, we'll send it straight to your pharmacy. All in one 10–minute session.

REGISTER FOR FREE

Smartphone or Tablet Apps

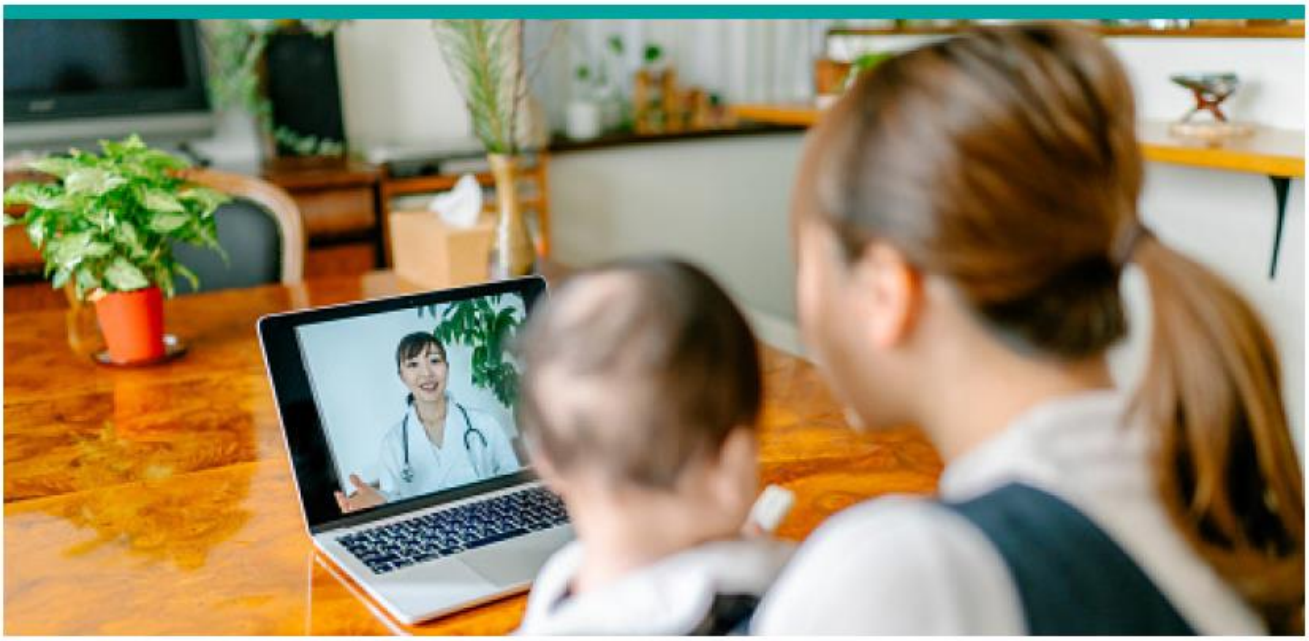
Download app from the Apple App Store — Available on the App Store

Download app from the Android Market — Google play

Register from Your Desktop or Laptop
clevelandclinicexpresscareonline.org

Telehealth Services

A Convenient Way to Stay Connected with Your Providers



Telehealth appointments allow you to stay connected with your providers and obtain needed medical care through live video chats using a computer or mobile device.

What is telehealth?

Telehealth visits are a virtual way to connect with your healthcare providers. Telehealth visits can be done by computer, tablet or smartphone. Visits include both an audio and visual component, meaning you can see and hear your provider during the visit, just as if you were talking face to face.

Are telehealth visits covered under my plan?

As with any health benefit, your plan determines how virtual visits are covered. Generally speaking, scheduled virtual visits are covered the same as a standard office visit. You can use telehealth for on-demand and scheduled visits for routine care for acute conditions, such as a sore throat or sinus infection, or chronic health conditions, such as diabetes or high blood pressure. Behavioral health visits are not covered in on-demand settings.

Do I need to make an appointment for a telehealth visit?

You can make an appointment for a telehealth visit with your provider just like you would schedule a regular office visit. This is called a scheduled telehealth visit.

If you need to speak to a healthcare provider right away, you can use an on-demand telehealth service, if it is covered by your plan. An on-demand telehealth visit is similar to walking in to an urgent care center. You do not need to schedule an appointment. You can log in for a telehealth visit anytime and you will be assigned to the first available provider. Contact your local in-network hospital system or check their website to find out if they offer on-demand telehealth visits.

Note: Please check your benefit documents by logging in to My Health Plan or call Customer Care using the number on your ID card.

What is the cost for a telehealth visit?

The amount you pay for a telehealth visit depends on your benefit plan. Typically, the copay for a telehealth visit would be the same as the copay for a standard office visit. If your plan includes on-demand telehealth visits, the copay may be different than a standard office visit. Please check your benefit documents by logging in to My Health Plan or call Customer Care using the phone number listed on your ID card.

Do I need any special equipment to participate in a telehealth visit?

Telehealth visits can be done through a smartphone, tablet or computer. Most devices have cameras built in, or you can use a standalone webcam. Your healthcare provider will let you know what you'll need to connect for your telehealth visit. It usually involves downloading a mobile app, such as FaceTime or Zoom, or logging in to a website. Some providers may use an online tool that is part of an electronic health record. You may be required to complete a registration process prior to your appointment.

How should I prepare for a telehealth visit?

Prepare for your telehealth appointment the same as you would for a face-to-face visit with your provider. Here are a few tips:

- Be prepared to explain your symptoms and any health concerns you are having
- Make a list of medications or supplements you're taking and ask for refills, if needed
- Note any allergies and discuss them with your provider

In addition, you should check your internet connection and test your camera before logging in for your telehealth visit. Try to find a quiet space for your telehealth visit where you can have a private conversation with your provider.

MEDICAL MUTUAL

MedMutual Find a Provider

Finding Care and Estimating Costs

MedMutual Find a Provider makes it easy to compare doctors, facilities and estimated costs so you can make the best decision for your health and wallet.

How to Get Started

1. Log in to My Health Plan at MedMutual.com/Member or via the MedMutual mobile app.
2. Select Find a Provider & Cost Estimates from the Quick Links section in the middle of the page or from the Resources & Tools tab at the top of the page.
3. Choose the Medical + Costs tile.

How to Search for In-network Doctors and Facilities

Search for in-network providers by name, specialty, location and more. Search results are customized to your plan and based on your home address, or you can choose to search from a different location. Select one of the following to begin:

- **Doctors by name:** See locations, network status and a specific doctor accepts new patients.
- **Doctors by specialty:** Find doctors in your network who specialize in certain conditions.
- **Places by name:** See address, hours, network status and other important information.
- **Places by type:** Search for in-network hospitals, labs or urgent care clinics near you.
- **Search all:** Search all categories by entering a name or phrase.
- **Advanced search:** Refine your search criteria based on location, languages spoken, which providers are accepting new patients, and more.

Once you make a selection, learn more by clicking **View Profile**, add the provider to a comparison list by checking the **Add to Compare**, or refine your search by clicking **More Filters**.

How to Compare Costs

Healthcare costs can vary by hundreds or even thousands of dollars depending on which doctor and facility you visit. Use MedMutual Find a Provider to understand your options and estimate your costs before you schedule an appointment or procedure. Because cost estimates are based on your benefit plan, you'll be able to see how costs may impact your annual deductible and out-of-pocket spending.

Select **Estimate Your Costs** to begin:

- Enter the procedure name or CPT code(s).
- Review the range of average costs within your search area.
- Compare the individual cost estimates for each matching provider.

Note: Estimates may be for just one part of a surgery or procedure. Some services like anesthesia and doctor's fees may be billed separately. To increase the accuracy of your cost estimate, ask your provider for all CPT codes involved in your procedure.

Some procedures or services covered by your plan may require prior approval from Medical Mutual. Please refer to your Certificate/Benefit Book, which is located under the Benefits & Coverage tab in My Health Plan or contact Medical Mutual Customer Care at the number on your member ID card.

MEDICAL MUTUAL

Online Tools from Medical Mutual

Smart, Simple, Safe

Here are three ways online tools from Medical Mutual make your health insurance information accessible 24 hours a day, no matter where you are. Visit MedMutual.com/Member to register.

My Health Plan

- Understand your out-of-pocket spending with real-time deductible and coinsurance information
- Find doctors and hospitals in your network, and compare quality and satisfaction ratings
- Estimate costs—know before you go and save money

Go Paperless

- Receive your Explanation of Benefits (EOB), certificate books and other documents electronically
- There's no need to keep paper files—we'll store the records for you
- Keep your health information secure—it's safer and a week faster than mail

Download the Mobile App

- Use our most popular My Health Plan features when you're on the go
- Find providers, estimate costs, check claims, and fax or email your ID card
- Download the app today for free from the Apple App Store® or Google Play™ by searching for MedMutual

Get started now at MedMutual.com/Member.

MEDICAL MUTUAL®

› Basic Employee Assistance Program

Life's not always easy. Sometimes a personal or professional issue can get in the way of maintaining a healthy, productive life. Your Employee Assistance Program (EAP) can be the answer for you and your family.

WE'RE HERE TO HELP

Mutual of Omaha's EAP assists employees and their eligible dependents with personal or job-related concerns, including:

- Emotional well-being
- Family and relationships
- Legal and financial
- Healthy lifestyles
- Work and life transitions

EAP BENEFITS

- Unlimited telephone access to EAP professionals 24 hours a day, seven days a week
- Telephone assistance and referral
- Service for employees and eligible dependents
- Legal assistance and financial services
  - Online will preparation
  - Legal library & online forms
  - Telephonic financial consultation
- Resources for:
  - Financial tools and resources
  - Substance abuse and other addictions
  - Dependent and elder care assistance & referral services
- Access to a library of educational articles, handouts and resources via *mutualofomaha.com/eap*

WHAT TO EXPECT

You can trust your EAP professional to assess your needs and handle your concerns in a confidential, respectful manner. Our goal is to collaborate with you and find solutions that are responsive to your needs.

Your EAP benefits are provided through your employer. If additional services are needed, your EAP will help locate appropriate resources in your area.

Don't delay if you need help. Visit *mutualofomaha.com/eap* or call 800-316-2796 for confidential consultation and resource services.

Benefits that work

Mutual of Omaha

Will Prep Services
Provided by **Epoq, Inc.**

Login

Will Prep Services

The smarter, simpler way to take care of what matters most

Protect your family and your property

Honestly, creating a will is one of those things that most of us would rather not talk about. But creating a will is an important investment in the future and an essential part of estate planning.

We work with Epoq, Inc. (Epoq) to provide affordable will preparation services. It's a benefit that helps employees protect what's important to them.

Epoq uses bank-level security to keep information safe and secure. And a personalized will can be created in just minutes.

1. Log on to Will Prep Services
2. Answer simple multiple choice questions
3. Download and print any document instantly

Who do I contact if I have questions regarding my benefits?

For general questions regarding your benefits, you may contact Shannon Shulters, HR Administrator at: 419-826-9515

Your Insurance Carriers Contact Information

If your question is in regards to how something is covered under a specific benefit or regarding a claim, you should contact your insurance carrier directly for the fastest answer. Below are carrier specific phone numbers:

Medical: Medical Mutual of Ohio: 800-382-5729
Principal Dental & Vision Claims: 800-247-4695
Principal/VSP: 800-877-7195
Group Life: Mutual of Omaha: 800-228-7104
Short Term Disability: Mutual of Omaha: 800-228-7104

What do I do if I am not sure a medical bill was properly paid?

Collect all billing statements and Explanations of Benefits (EOBs) that relate to your claim. Match up the bills with the EOBs, so you can compare how the insurance company processed the claim with how you've been billed. (If you don't have a matching EOB, call the number on your ID card to make sure the insurance company received it.) If the amounts don't match, call your doctor's office and ask them why you're being billed a different amount from what the EOB says you owe.

Who do I contact with additional questions?

If you have tried to resolve an issue with the insurance company on any of the following items and are unable to get the answers you need, Stapleton Insurance can help! Your representative's name is Alissa Pickett and she can be reached at 1-877-720-6446 or Alissa@Stapletoninsurance.com

- Plan information or explanation
- Help with claims
- Information on eligibility
- Help with doctor, hospital or other provider issues
- Help with prescriptions

What changes can I make during open enrollment?

You can enroll or terminate individual and/or dependent coverage in all the plans offered to you in this guide.

When and how do I get my ID cards?

You will receive your ID cards at your home 7-10 days after your application has been processed. To request replacement or additional cards, you can log onto the carrier specific websites and make a request.

What forms do I need to complete at initial enrollment, or with a qualifying event?

You will need to complete a provider specific enrollment form for each coverage you wish to purchase and/or participate in. Forms to be completed:

- Medical: Medical Mutual
- Dental and Vision: Principal
- Basic Life, Short Term Disability: Mutual of Omaha

When are the forms due and where do I return them?

New Hire: Return to HR no later than 30 days prior to your effective date of coverage

Open Enrollment: Month of December

Summary of Benefits and Coverages (SBC) and Summary Plan Description

SBC's will be provided to each employee at initial enrollment, and during open enrollment. SBC's are always available when requested. Please contact HR if you did not receive your copy.

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was made to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.

Village of Swanton reserves the right to alter, revise, modify or otherwise make changes to this policy at any time, with or without notice.

Women's Health and Cancer Rights Act

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:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Coverage for prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas, as determined during a consultation with the attending physician and patient.

These benefits will be provided subject to annual deductibles and coinsurance provisions as appropriate and consistent with those established for other benefits under the health plan.

Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers generally may not, 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 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).

Plans cannot set the level of benefits or out-of-pocket costs so that any later portion of the 48- or 96-hour stay is treated in a less favorable manner for the mother or newborn than any earlier part.

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). However, a mother may be required to receive prior approval to use certain providers or facilities, or to reduce out-of-pocket costs. If your plan contains a precertification requirement, you or your provider must still get prior approval for the stay to avoid any additional out-of-pocket expenses. However, your stay will automatically be approved for 48 or 96 hours, as specified by law.

COBRA or State Continuation

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) generally provides that certain qualified beneficiaries who lose coverage under an employer-sponsored health plan may elect to continue under the plan in certain situations. This is for groups with over 20 employees. State Continuation is applicable for smaller employee.

Medicare & Medicare Part D

If you are 65 or older and are actively at work, working full time you may remain on our group health insurance plan as Primary. In some instances, it may be beneficial to review options to enroll with Medicare Part A & B, Medicare Supplements and Medicare Part D.

If you or your dependent is eligible for Medicare, you (or they) may defer enrollment into one of Medicare Part D programs until later, since you are already covered under our employer-sponsored prescription drug plan. People who are eligible to enroll in Medicare Part D benefits at age 65, but decide not to enroll until later, will have the opportunity to enroll in Part D benefits between October 15th and December 7th each year during open enrollment. We have determined that the prescription drug coverage offered by our plan 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. This will allow you to keep your current coverage and not pay a higher premium (penalty) if you later decide to join a Medicare drug plan.

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 are 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 are not eligible for Medicaid or CHIP, you will not 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 healthcare.gov. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State offering premium assistance, contact your State Medicaid or CHIP office to determine if premium assistance is available to you. More information is available at Medicaid.gov under the CHIP tab. 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 877-KIDS-NOW or insurekidsnow.gov to find out how to apply. If you qualify, ask your State if it has a program that will 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 are not 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 regarding enrolling in your employer plan, contact the Department of Labor at askebsadol.gov or call 866-444-EBSA (3272).

Premium Expense Plan (Section 125)

The Premium Expense Plan is allowed under the IRS tax code. It reduces your amount of taxable income by allowing you to pay for your insurance premiums on a pre-tax basis. All employees participating in the insurance plans are eligible, and an Authorization Form is required. IMPORTANT NOTICE: In accordance with federal regulations, the benefits you choose will remain in effect through the next plan year. However, you may be allowed to make changes in certain benefits if you have a Qualified Event. Qualified Events are limited to the following: - Marriage – Legal Separation – Annulment or Divorce – Death of a spouse or dependent – Birth or adoption of a child or addition of a dependent – Loss of eligibility of a dependent child – Termination or commencement of a spouse's employment.

Michelle's Law

Michelle's Law prevents a group health plan from terminating your dependent child's coverage if he or she is no longer a full-time student due to a medically necessary leave of absence. A medically necessary leave of absence is a leave of absence from a post-secondary educational institution resulting from a serious illness or injury that causes your child to lose eligibility under your health plan. To qualify for this protection, your child must:

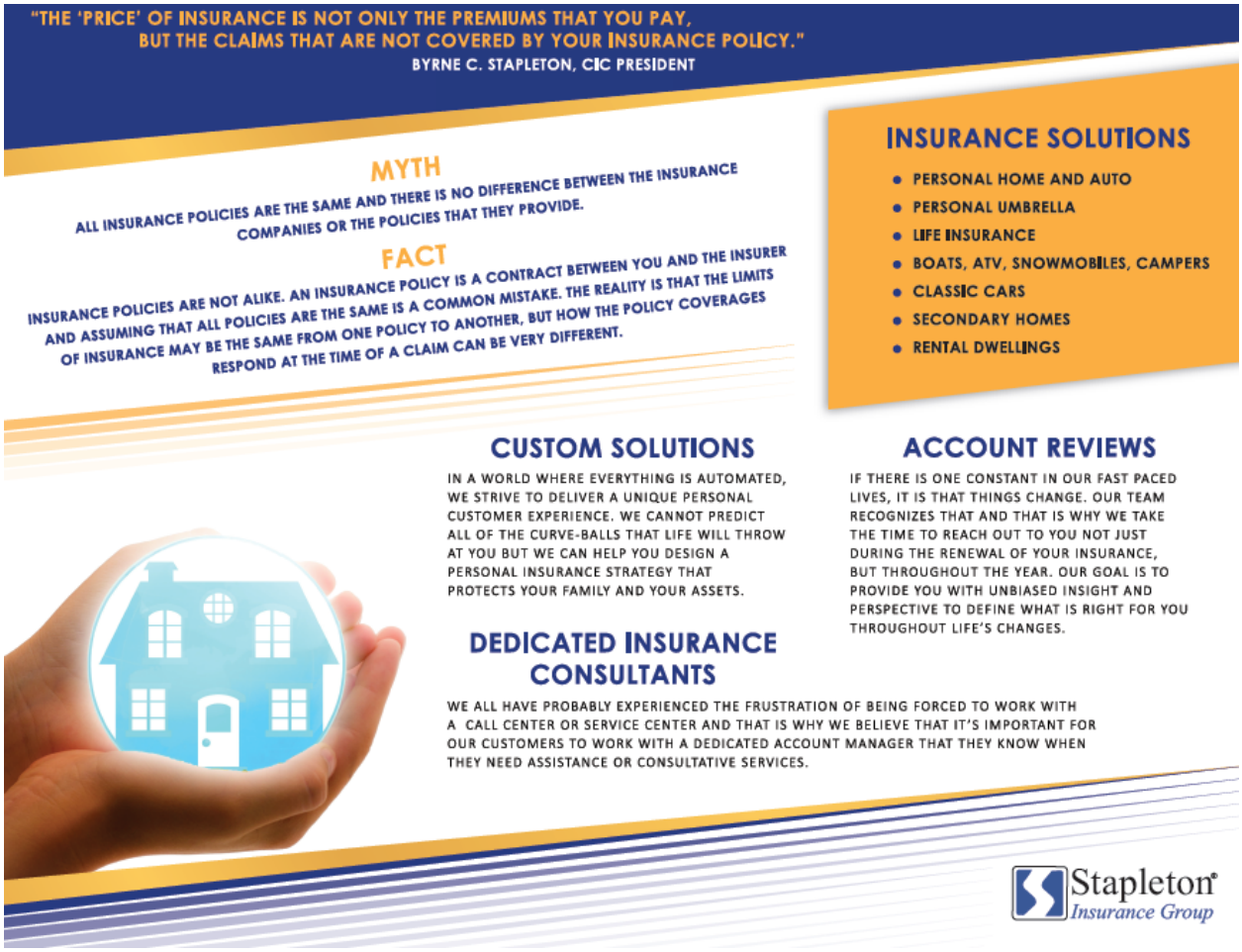
- Be qualified as a dependent under the terms of your health plan;
- Be enrolled in your health plan as a student attending a post-secondary educational institution as of the day before the medically necessary leave of absence started; and
- Have written certification by a treating physician indicating he or she is suffering from a serious illness or injury and the leave of absence is medically necessary.

Keep in mind, your children can be covered to age 26, regardless of student status.

HIPPA Privacy Policy

Want to receive a copy of the Group Health Plan's Notice of Privacy Practices? Contact your employer's privacy or benefits department.

Not only can we help with your employer provided benefits, we can also provide an account review of your personal insurance. Stapleton Insurance is here to help with all your insurance needs. Contact Wendy Schmidt (419) 517-9806 for your personal review.



90 YEAR ANNIVERSARY
Stapleton Insurance Group
1927-2017