

NORTHWEST
+HEALTH
SERVICES

**We ♥ our
employees!**

2024 EMPLOYEE BENEFITS BROCHURE



Medical - HSA



BlueCross BlueShield
of Kansas City

| | Network | Non-Network |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|---------------------|
| Deductible | | |
| Individual | \$3,200 | \$3,200 |
| Family | \$6,400 | \$6,400 |
| Co-Insurance | 100% | 80% |
| Out-of-Pocket Maximum (Includes deductible, co-insurance, per visit and RX copays) | | |
| Individual | \$3,200 | \$6,400 |
| Family | \$6,400 | \$12,800 |
| Common Services | | |
| Physician Office Visits | | |
| Primary Care | Deductible then 100% | Deductible then 80% |
| Specialist | Deductible then 100% | Deductible then 80% |
| Hospital Services Inpatient & Outpatient | | |
| | Deductible then 100% | Deductible then 80% |
| Diagnostic Lab & X-Ray | | |
| | Deductible then 100% | Deductible then 80% |
| Urgent Care (Includes lab only) | | |
| | Deductible then 100% | Deductible then 80% |
| Emergency Room | | |
| | 100% after \$150 In-Network Deductible | |
| Preventive Services (Includes Well Woman Exam, Prostate Exam, Skin Cancer Screening, Routine Physical Exam, and Well Baby Care) | | |
| | 100% (Deductible Waived) | Deductible then 80% |
| Prescription Drugs 30-day - Retail (90-day mail order twice the retail copay) | | |
| Generic | Deductible then 100% | Deductible then 50% |
| Brand - Preferred | Deductible then 100% | Deductible then 50% |
| Brand - Non-Preferred | Deductible then 100% | Deductible then 50% |

HSA Medical Rates - Cost Per Pay Period

| | |
|---------------------|----------|
| Employee Only | \$25.05 |
| Employee Spouse | \$140.43 |
| Employee Child(ren) | \$120.25 |
| Family | \$208.03 |

Medical - Base



BlueCross BlueShield
of Kansas City

| | Network | Non-Network |
|----------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----------------------------------|
| Deductible | | |
| Individual | \$2,800 | \$2,800 |
| Family | \$5,600 | \$5,600 |
| Co-Insurance | 100% | 80% |
| Out-of-Pocket Maximum (Includes deductible, co-insurance, per visit and RX copays) | | |
| Individual | \$2,800 | \$5,600 |
| Family | \$5,600 | \$11,200 |
| Common Services | | |
| Physician Office Visits | | |
| Primary Care | 100% after \$10 Copay | 80% after \$10 Copay |
| Specialist | 100% after \$30 Copay | 80% after \$30 Copay |
| Hospital Services Inpatient & Outpatient | | |
| | Deductible then 100% | Deductible then 80% |
| Diagnostic Lab & X-Ray | | |
| | Deductible then 100% | Deductible then 80% |
| Urgent Care (Includes lab only) | | |
| | Deductible then 100% | Deductible then 80% |
| Emergency Room | | |
| | 100% after Deductible | |
| Preventive Services (Includes Well Woman Exam, Prostate Exam, Skin Cancer Screening, Routine Physical Exam, and Well Baby Care) | | |
| | 100% (Deductible Waived) | Deductible then 80% |
| Prescription Drugs 30-day - Retail (90-day mail order twice the retail copay) | | |
| Generic | \$15 Copay | Deductible then 50% + \$15 Copay |
| Brand - Preferred | \$35 Copay | Deductible then 50% + \$30 Copay |
| Brand - Non-Preferred | \$70 Copay | Deductible then 50% + \$70 Copay |

| NHS Medical Rates - Cost Per Pay Period | |
|------------------------------------------------|----------|
| Employee Only | \$29.80 |
| Employee Spouse | \$148.72 |
| Employee Child(ren) | \$128.93 |
| Family | \$220.40 |

This document is intended to give a summary description of the plan and is not a contract. For complete benefit information please refer to the plan documents for each benefit. In the event of a discrepancy between this brochure and the plan document, the plan document will prevail. Possession of this document is not a guarantee of coverage.

Medical - Buy-Up



BlueCross BlueShield
of Kansas City

| | Network | Non-Network |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------|
| Deductible | | |
| Individual | \$1,000 | \$1,000 |
| Family | \$2,000 | \$2,000 |
| Co-Insurance | 80% | 60% |
| Out-of-Pocket Maximum (Includes deductible, co-insurance, per visit and RX copays) | | |
| Individual | \$3,000 | \$6,000 |
| Family | \$6,000 | \$12,000 |
| Common Services | | |
| Physician Office Visits | | |
| Primary Care | \$10 Copay | Deductible then 60% |
| Specialist | \$30 Copay | Deductible then 60% |
| Hospital Services Inpatient & Outpatient | Deductible then 80% | Deductible then 60% |
| Diagnostic Lab & X-Ray | Deductible then 80% | Deductible then 60% |
| Urgent Care (Includes lab only) | Deductible then 80% | Deductible then 60% |
| Emergency Room | \$150 Copay | |
| Preventive Services (Includes Well Woman Exam, Prostate Exam, Skin Cancer Screening, Routine Physical Exam, and Well Baby Care) | 100% (Deductible & Copay Waived) | Deductible then 60% |
| Prescription Drugs 30-day - Retail (90-day mail order twice the retail copay) | | |
| Generic | \$10 Copay | Deductible then 50% + \$10 Copay |
| Brand - Preferred | \$30 Copay | Deductible then 50% + \$30 Copay |
| Brand - Non-Preferred | \$50 Copay | Deductible then 50% + \$50 Copay |

Buy-Up Medical Rates - Cost Per Pay Period

| | |
|---------------------|----------|
| Employee Only | \$56.31 |
| Employee Spouse | \$194.96 |
| Employee Child(ren) | \$177.37 |
| Family | \$289.47 |

Dental



Predetermination of Benefits: Before treatment begins for inlays, onlays, single crowns, prosthetics, periodontics and oral surgery, you may file a dental treatment plan with Guardian. Guardian will provide a written response indicating benefits that may be payable for the proposed treatment.

This chart provides you a brief summary of the key benefits of the dental coverage available from Guardian. For a complete list of all your dental coverage benefits and restrictions, please see your official plan documents.

| PPO Plan | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|-------------|
| | In-Network DentalGuard Preferred Network | Non-Network |
| Calendar Year Deductible | | |
| Individual | \$25 | \$50 |
| Family Limit | \$75 | \$150 |
| Waived For | Preventive | Preventive |
| Charges Covered For You (Co-Insurance) | | |
| Preventive Care | 100% | 100% |
| Basic Care | 80% | 80% |
| Major Care | 50% | 50% |
| Orthodontia (under age 19) | 25% | 25% |
| Benefit Maximum | | |
| Annual Maximum Benefit | \$2,000 | |
| Preventive Services Exempt from Maximum | Yes | |
| Lifetime Orthodontia Maximum | \$1,500 | |
| Dependent Age Limit | 26 | |
| Maximum Rollover | | |
| To qualify for a \$1,250 Maximum Rollover Account, you must have a paid claim (not just a visit) and must not have exceeded the paid claims threshold during the benefit year. See your official plan documents for more detail. | | |

| Dental Rates | |
|---------------------|---------------------|
| | Cost Per Pay Period |
| Employee Only | \$0.00 |
| Employee Spouse | \$15.67 |
| Employee Child(ren) | \$15.73 |
| Family | \$32.98 |



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Additional Discounts

40% OFF

Complete pair of prescription eyeglasses

20% OFF

Non-prescription sunglasses

20% OFF

Remaining balance beyond plan coverage

These discounts are for in-network providers only

Take a sneak peek before enrolling

- You're on the INSIGHT Network
- For a complete list of **in-network** providers near you, use our **Enhanced** Provider Locator on www.eyemed.com or call **1-866-804-0982**.
- For Lasik providers, call 1-877-5LASER6.

SUMMARY OF BENEFITS

| Vision Care Services | In-Network Member Cost | Out-of-Network Reimbursement |
|--------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------|
| Exam With Dilation as Necessary | \$10 Co-pay | Up to \$40 |
| Retinal Imaging | Up to \$39 | N/A |
| Frames | \$0 Co-pay; \$130 allowance; 20% off balance over \$130 | Up to \$91 |
| Standard Plastic Lenses | | |
| Single Vision | \$25 Co-pay | Up to \$30 |
| Bifocal | \$25 Co-pay | Up to \$50 |
| Trifocal | \$25 Co-pay | Up to \$70 |
| Standard Progressive Lens | \$90 Co-pay | Up to \$80 |
| Premium Progressive Lens ^Δ | \$110 Co-pay - \$135 Co-pay | |
| Tier 1 | \$110 Co-pay | Up to \$50 |
| Tier 2 | \$120 Co-pay | Up to \$50 |
| Tier 3 | \$135 Co-pay | Up to \$50 |
| Tier 4 | \$90 Co-pay, 80% of charge less \$120 Allowance | Up to \$50 |
| Lenticular | \$25 Co-pay | Up to \$70 |
| Lens Options (paid by the member and added to the base price of the lens) | | |
| UV Treatment | \$15 | N/A |
| Tint (Solid and Gradient) | \$15 | N/A |
| Standard Plastic Scratch Coating | \$15 | N/A |
| Standard Polycarbonate | \$40 | N/A |
| Standard Polycarbonate - Kids under 19 | \$40 | N/A |
| Standard Anti-Reflective Coating | \$45 | N/A |
| Premium Anti-Reflective Coating ^Δ | \$57 - \$68 | N/A |
| Tier 1 | \$57 | N/A |
| Tier 2 | \$68 | N/A |
| Tier 3 | 80% of charge | N/A |
| Photochromic/Transitions | \$75 | N/A |
| Polarized | 20% off retail price | N/A |
| Other Add-Ons and Services | 20% off retail price | N/A |
| Contact Lens Fit and Follow-Up (Contact lens fit and two follow up visits are available once a comprehensive eye exam has been completed) | | |
| Standard Contact Lens Fit & Follow-Up | Up to \$55 | N/A |
| Premium Contact Lens Fit & Follow-Up | 10% off retail | N/A |
| Contact Lenses | | |
| Conventional | \$0 Co-pay; \$130 allowance; 15% off balance over \$130 | Up to \$130 |
| Disposable | \$0 Co-pay; \$130 allowance; plus balance over \$130 | Up to \$130 |
| Medically Necessary | \$0 Co-pay, Paid-in-Full | Up to \$210 |
| Laser Vision Correction | | |
| Lasik or PRK from U.S. Laser Network | 15% off the retail price or 5% off the promotional price | N/A |
| Hearing Care | | |
| Hearing Health Care from Amplifon Hearing Network | 40% off hearing exams and a low price guarantee on discounted hearing aids | N/A |
| Frequency | | |
| Examination | Once every 12 months | |
| Lenses or Contact Lenses | Once every 12 months | |
| Frame | Once every 24 months | |

Vision Rates

| | Cost Per Pay Period |
|---------------------|---------------------|
| Employee Only | \$3.18 |
| Employee Spouse | \$6.04 |
| Employee Child(ren) | \$6.36 |
| Family | \$9.35 |

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Group Life



Employer Paid - to all employees working a minimum of 20 hours a week.

- The benefit is equal to 1x your annual salary, up to \$50,000 maximum.
- Beneficiary information can be updated as needed throughout the year.
It is important to have up-to-date information on file with Northwest Health Services.
- Coverage amount(s) will reduce according to the following schedule:
65% at age 70
45% at age 75

Long-term Disability



Employer Paid - to all employees working a minimum of 20 hours a week.

- The benefit is equal to 60% of your base wage to a maximum monthly benefit of \$10,000.
- Pre-existing condition exclusion: 3/12.



Voluntary Life



Employee Paid

Your Term Life and AD&D coverage options are:

Employee: Up to 5 times salary in increments of \$10,000
Not to exceed \$500,000.

Spouse: Up to 100% of employee amount in increments of \$5,000.
Not to exceed \$500,000. Benefits will be paid to the employee.

Child: Up to 100% of employee coverage amount in increments of \$5,000.
Not to exceed \$10,000.

The maximum death benefits for a child between the ages of live birth and 6 months is \$1,000. Benefits will be paid to the employee.

If you and your eligible dependents enroll within 31 days of your eligibility date, you may apply for any amount of life insurance coverage up to \$140,000 for yourself and any amount of coverage up to \$30,000 for your spouse. Any life insurance coverage over the Guarantee Issue amount(s) will be subject to evidence of insurability.

If you and your eligible dependents do not enroll within 31 days of your eligibility date, you can apply for coverage only during your annual enrollment period and will be required to furnish evidence of insurability for the entire amount of coverage.

Rates

| Employee Age | Employee Monthly Rate Per \$10,000 | | Spouse Monthly Rate Per \$5,000 | Child Rate Per \$5,000 |
|---------------------------|------------------------------------|---------|---------------------------------|---------------------------|
| | Non-Tobacco | Tobacco | | |
| 15-24 | \$0.40 | \$0.67 | \$0.20 | \$1.00 |
| 25-29 | \$0.40 | \$0.67 | \$0.20 | |
| 30-34 | \$0.50 | \$0.87 | \$0.25 | |
| 35-39 | \$0.78 | \$1.40 | \$0.39 | |
| 40-44 | \$1.13 | \$2.06 | \$0.57 | |
| 45-49 | \$1.74 | \$3.24 | \$0.87 | |
| 50-54 | \$2.84 | \$5.33 | \$1.42 | |
| 55-59 | \$4.64 | \$8.52 | \$2.32 | |
| 60-64 | \$7.46 | \$12.82 | \$3.73 | |
| 65-69 | \$13.99 | \$22.87 | \$7.00 | |
| 70-74 | \$28.82 | \$41.47 | \$35.08 | |
| 75-79 | \$28.82 | \$41.47 | \$57.84 | |
| Voluntary AD&D | Employee Monthly Rate | | Spouse Monthly Rate | Child Monthly Rate |
| | \$0.20 Per \$1,000 | | \$0.10 Per \$5,000 | \$0.10 Per \$5,000 |

NOTE: Spouse rate is based on employee's insurance age. Your rate will increase as you age and move to the next age band. Your rate is based on your insurance age, which is your age immediately prior to and including the anniversary/effective date.

Health Savings Account

Your UMB Health Savings Account (HSA) is a versatile tool that allows you to decide whether to spend your money to pay for qualified medical expenses or save your money to allow your HSA to grow for future expenses like retirement. Qualified medical expenses are defined by the IRS Code Section 213(d) and include amounts paid for your medical needs.

The IRS requires that you keep itemized receipts to document your withdrawals. Your qualified tax free HSA withdrawals may be expenses made by you, your spouse, or your eligible dependents, regardless of whether they are covered on the medical plan or not.

Start a Savings Plan for Your Health

By enrolling in your company's high-deductible health plan you may be eligible to open and save in a health savings account (HSA) from United Missouri Bank, Member FDIC. Here is some information about how an HSA works and directions for getting started.

What is an HSA?

Think of an HSA as a savings plan for health care you'll need today, tomorrow and into the future. It works like a regular bank account, but you don't pay federal income tax on the money you deposit. When you use your HSA money to pay for qualified medical expenses, you won't pay income taxes on the money, either. You even build your savings into a nest egg for retirement.

Unlike a flexible spending account (FSA), your savings grow from year to year. There's no "use it or lose it" rule. The money is there when you need it. And it's yours to keep.

Why have an HSA?

An HSA simply helps you plan, save and pay for health care.

You own it.

The money belongs to you, even deposits made by others, such as an employer or family member. You keep it, even if you change jobs or health plans.

It has triple tax benefits.

- Money deposited is federal income tax-free.
- Savings grow tax-free.
- Withdrawals made for qualified expenses are also income-tax free.

Anyone can contribute.

You, your employer or a loved-one. There are no restrictions on who can put money into your account.

It's not just for doctor visits.

You can use your HSA to pay for medical needs such as eyeglasses, hearing aids and qualified prescriptions. You can even use your savings to pay for other kinds of health insurance, such as COBRA, long-term care and any health plan coverage you have while receiving unemployment compensation. When you turn 65, you can use HSA savings to pay for any tax deductible health insurance (except for Medicare supplemental insurance).

You can invest it.

Once your balance reaches the investment threshold, you can begin investing in mutual funds. If you earn money on your investments, you don't pay income tax on that money, either.

You can save for the future.

By saving in an HSA, you can be ready for expenses due to illness or accident. And, after you turn 65 or become entitled to Medicare benefits, you may withdraw money from your HSA for expenses that are not qualified medical expenses which are subject to standard income taxes, without penalty. Save as much as you can now, and you could possibly have a nest egg when you retire.

What else you need to know about an HSA

Eligibility rules apply.

To deposit money into an HSA, you must be enrolled in an HSA-eligible health plan. You are eligible if:

- You are covered under an eligible high deductible health plan (HDHP).
- You are covered by no other health coverage, unless it is permissible coverage like vision or dental.
- You are not enrolled in Medicare.
- You cannot be claimed as a dependent on someone else's tax return.

Some other restrictions apply. Please consult your tax, benefits or financial advisor.

If you switch to a health plan that makes you ineligible to continue depositing money in an HSA, you may continue to use the money in your account for qualified medical expenses, but you can no longer make deposits.

Contribution limits are determined every year by the IRS.

For 2024, you can deposit up to \$4,150 if you have individual coverage and \$8,300 if you have a family policy. The IRS also allows you to make an extra catch-up deposit of \$1,000 if you are 55 or older.

You can make contributions all the way up to the tax-filing deadline (usually April 15) and still get tax credit for the previous year.

Flexible Spending Account Southern BANK

A Flexible Spending Account (FSA) is a valuable employee benefit. Under IRS Code 125, employees can set aside pre-tax dollars from their paycheck and be reimbursed with those dollars throughout the year for qualified medical, daycare, and other allowable expenses. Depending on your personal situation, you may want to participate in one or a combination of the available accounts within the FSA. As qualified expenses are incurred, you are reimbursed from the account with your pre-tax dollars. For every dollar set aside from your paycheck to the plan, you save on taxes that are not withheld. By reducing your income taxes, you increase your take-home pay.

Employees have the option to elect a healthcare FSA and/or a dependent care FSA administered by Southern Bank.

Healthcare Flexible Spending Account

Healthcare expenses that are not covered by insurance can be reimbursed through a healthcare FSA. Examples of qualified expenses include copays, deductibles, prescriptions, eye glasses or contacts, dental services, and more.

Annual Contribution Limit for 2024: \$3,200

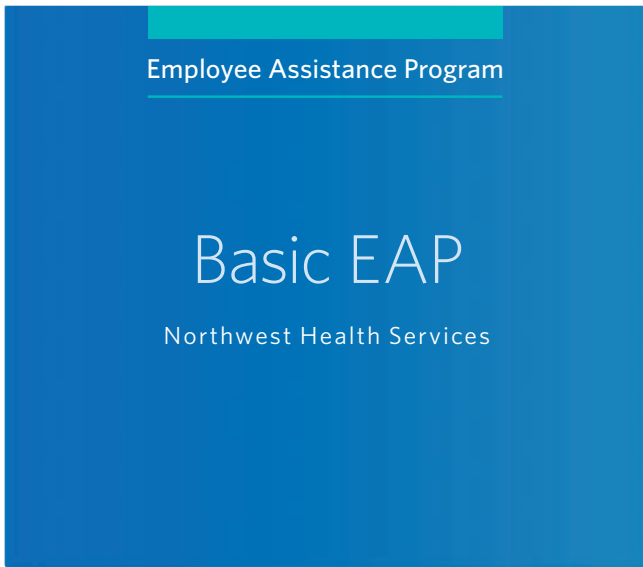
“Use-It-or-Lose-It” Rule: Remember to fund based on your needs. At the end of the plan year, any unused funds will be forfeited, with the exception of \$640.

Dependent Care Flexible Spending Account - Southern Bank

Dependent care can be costly. Using the Dependent Care FSA, you can pay for qualified care costs for a child or adult. You pay for the expense when incurred, and then submit a reimbursement claim form or file a claim online for reimbursement. Remember that both spouses or custodial parents must be employed and dependent must be:

- A child under age 13 or;
- A child, spouse or other dependent who is physically or mentally incapable of self-care and spends at least 8 hours in your household.

Annual Contribution Limit for 2024: \$5,000



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 Life Styles
- Work and Life Transitions

EAP Benefits

- Access to EAP Professionals 24 hours a day, seven days a week
- Provides information and referral resources
- Service for employees and eligible dependents
- Online resources for:
 - *Substance use and other addictions*
 - *Dependent and Elder Care resources*

- Access to a library of educational articles, handouts and resources via mutualofomaha.com/eap
 - *Legal library and online forms*
 - *Financial and online tools*

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.

Legal Notices

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards 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).

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

Notice of Patient Protections

Your plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you can designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Human Resources Department.

You do not need prior authorization from your plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Human Resources Department.

Women's Health and Cancer Rights Act

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.

Newborns' and Mothers' Health Protection Act

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

HIPAA Privacy

Your employer is required by law to take reasonable steps to ensure the privacy and inform you about the uses of your protected health information (PHI). The use and disclosure of PHI is regulated by the federal law known as HIPAA (the Health Insurance Portability and Accountability Act). A more complete description of your privacy rights and protections is available to you on request. Contact the Human Resources Department with any questions or to request a copy of the full HIPAA privacy notice.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

KANSAS - Medicaid

Website: <https://www.kancare.ks.gov/>

Phone: 1-800-792-4884

HIPP Phone: 1-800-967-4660

MISSOURI - Medicaid

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>

Phone: 573-751-2005

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefits Security Administration

www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565

Notices



Health Insurance Marketplace Coverage Options & Your Health Coverage

General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in November 1, 2023 for coverage starting as early as January 1, 2024.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 8.39% of your household income for the year, or if the coverage your employer provides does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your Human Resources Department.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Notices

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

“Out-of-network” describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “**balance billing**.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

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Your Rights and Protections Against Surprise Medical Bills cont.

You're **never** required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the entity responsible for enforcing the federal and/or state balance or surprise billing protection laws. Visit <https://www.commonwealthfund.org/publications/maps-and-interactives/2022/feb/map-no-surprises-act#map> for information and to view the No Surprises Act Map.

For more information about the impact of the No Surprises Act on consumers, including how to file complaints, please refer to the Centers for Medicaid and Medicaid Services' [No Surprises Act Consumer FAQ page](#).

Visit <https://www.cms.gov/nosurprises/policies-and-resources/overview-of-rules-fact-sheets> for more information about your rights under federal law.

Visit <https://www.ncsl.org/health/surprise-and-balance-billing-state-policy-options> for more information about your rights under state law.

To contact state regulators regarding the No Surprises Act, please [click here](#) for agency websites.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

Contacts

Medical

Blue Cross Blue Shield of Kansas City
888.989.8842
www.bluekc.com

Dental

Guardian
888.600.1600
www.guardiananytime.com

Vision

EyeMed
866.939.3633
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Life/AD&D and Disability

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