

Employee Benefits

January 2021

Presented by:

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Bernie Lowe & Associates, Inc.



NORTH RISK PARTNERS®



Bernie Lowe & Associates, Inc.

2021 Meeting Opportunities

Open Enrollment meetings will be held virtually this year. You will have two opportunities to tune in by dialing in from your phone and/or connecting virtually.

- Wednesday, October 28th, 12:00 p.m.
 - Dial in opportunity: (312)626-6799
 - Virtual Connect (with or without video): www.zoom.com and click “Join A Meeting”
 - Meeting ID: 848 0248 6341, Password: 414613 ← these are the same for phone or web
- Thursday, October 29th, 12:00 p.m.
 - Dial in opportunity: (312)626-6799
 - Virtual Connect (with or without video): www.zoom.com and click “Join A Meeting”
 - Meeting ID: 898 9255 6723, Password: 115511 ← these are the same for phone or web

Open Enrollment

This is a time for you to make enrollment changes to your benefits effective January 1, 2021 **without having a qualifying life change** as permitted under federal law. This annual open enrollment is for the following benefits:

- Health Plan ← 2021 New Options!
- Dental Plan ← No Changes
- Vision Plan ← No Changes
- Flex Spending ← No Changes

Intellectual Property & Confidentiality Agreement

The information contained in this booklet, including any subsequent amendments or additions, is proprietary and confidential. Accordingly, University of Iowa Community Medical Services and its officers, employees, consultants, attorneys, auditors and other persons retained by University of Iowa Community Medical Services shall refrain from, in any manner, appropriating to its own use, exploiting or using, selling, duplicating or distributing, directly or indirectly, any information provided in the proposal by Bernie Lowe & Associates, Inc, without the express written consent of Bernie Lowe & Associates, Inc. setting forth the terms and conditions of such use.

Disclosure

The benefit highlights provided in this booklet are intended to provide a brief description only. Other benefits and restrictions may apply. Refer to the actual contracts, plan documents, or benefit summaries for details.



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Medical and Prescription Drug Plan Benefit Highlights – (New!) HMO Plan

Benefit	Wellmark Health Plan of Iowa	
Insurance Provider	Fully-Insured, Wellmark	
Plan Name	Primary 1000 HMO	
	In-Network	Out of Network
Office Visit Including Chiropractic	\$25 PCP Type Copay \$50 Specialist Copay	Not Covered
Deductible	\$1,000 Single / \$3,000 Family	Not Covered
Coinsurance	80% / 20%	Not Covered
Out-of-Pocket	\$2,000 Single / \$4,000 Family	Not Covered
Adult Preventive Exam	No Charge (No PCP designation)	Not covered
Mental Health Substance Abuse	Treated as any other illness	
Urgent Care Visits	\$25 Copay	Not Covered
Emergency Room Visits	\$300 Copay	
Inpatient Hospital	Deductible + 20%	Not Covered
Outpatient Hospital	Deductible + 20%	Not Covered
Rx Benefits		
Retail: 30 day supply	Tier 1 - \$15 / Tier 2 - \$30 / Tier 3 - \$60 / Tier 4 - \$120 Preferred Specialty - \$175 / Non-preferred Specialty - \$225	
Mail Order: 90 day supply	3 Copays - Specialty excluded	
Vision Exam	\$50 Copay	Not Covered
<p>Guest Membership: Guest Membership Services are available for members traveling long-term, covered dependents attending college out of state, or covered family members living apart. If you will be residing outside of the network area for 90 days or more, call the Wellmark Customer Service number on your ID card. They will assist you in setting up your guest membership, discuss covered services, and research participating providers in the area of your destination. You will want to do this before leaving the Wellmark Health Plan Network area and each year at open enrollment if your out of state residency carries over from one plan year to another.</p>		

Plan variations from last year are indicated in red above. Please see your SBC for additional plan details.

Medical and Prescription Drug Plan Benefit Highlights – POS Plan

Benefit	Wellmark Health Plan of Iowa	
Insurance Provider	Fully-Insured, Wellmark	
Plan Name	Primary 1000 POS	
	In-Network	Out of Network
Office Visit Including Chiropractic	\$25 PCP Type Copay \$50 Specialist Copay	Deductible + 40%
Deductible	\$1,000 Single / \$3,000 Family	\$1,000 Single / \$3,000 Family <i>OON Deductible Accumulates Independently</i>
Coinsurance	80% / 20%	60% / 40%
Out-of-Pocket	\$2,000 Single / \$4,000 Family	\$2,000 Single / \$4,000 Family <i>OON OPM Accumulates Independently</i>
Adult Preventive Exam	No Charge	Deductible + 40%
Mental Health Substance Abuse	Treated as any other illness	
Urgent Care Visits	\$25 Copay	Deductible + 40%
Emergency Room Visits	\$300 Copay	
Inpatient Hospital	Deductible + 20%	Deductible + 40%
Outpatient Hospital	Deductible + 20%	Deductible + 40%
Rx Benefits		
Retail: 30 day supply	Tier 1 - \$15 / Tier 2 - \$30 / Tier 3 - \$60 / Tier 4 - \$120 Preferred Specialty - \$175 / Non-preferred Specialty - \$225	
Mail Order: 90 day supply	3 Copays - Specialty excluded	
Vision Exam	\$50 Copay	Not Covered

****Plan variations from last year are indicated in red above. Please see your SBC for additional plan details.****



Primary 1000 HMO



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.wellmark.com or call 1-800-524-9242. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-524-9242 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$1,000 person/ \$3,000 family per calendar year.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, certain outpatient hospital x-ray/labs, in-network prosthetic limbs, physician maternity care and services subject to health and drug card copayments are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No. There are no other specific deductibles. There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Health: \$2,000 person/ \$4,000 family per calendar year. Drug Card: \$2,000 person/ \$4,000 family per calendar year. The In-Network health and drug card out-of-pocket maximum amounts accumulate together.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.wellmark.com or call 1-800-524-9242 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why this Matters:
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .
 All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.		

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a <u>health care provider's office</u> or <u>clinic</u>	Primary care visit to treat an injury or illness	\$25 <u>copay</u> per <u>provider</u> per date of <u>service</u>	Not covered	Primary Care Practitioners (PCP) are defined as General and Family Practice, Internal Medicine, OB/GYN, Pediatricians, Nurse Practitioners and PAs.
	<u>Specialist</u> visit	\$50 <u>copay</u> per <u>provider</u> per date of <u>service</u>	Not covered	Applies to Non-PCP <u>providers</u> . \$25 <u>copay</u> per <u>provider</u> per date of service for <u>in-network</u> <u>chiropractic</u> services.
	<u>Preventive care</u> / <u>screening</u> / <u>immunization</u>	No charge	Not covered	One preventive exam and one gynecological exam per calendar year. One mammogram per calendar year. Well-child care is covered to age 7. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a <u>test</u>	<u>Diagnostic test</u> (x-ray, blood work)	Independent Lab: \$25 <u>copay</u> per <u>provider</u> per date of <u>service</u> Facility: 20% <u>coinsurance</u>	Not covered	For a test in a <u>provider's</u> office or clinic, your cost is included in the <u>cost-share</u> listed above. Waive <u>cost-share</u> on <u>in-network</u> independent lab services for mental health/ <u>substance</u> abuse.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	Not covered	-----None-----

#7 For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242. You can find your Coverage Manual at sbccmfinder.wellmark.com.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at www.wellmark.com/prescriptions.</p>	Tier 1	\$15 <u>copay</u> per prescription	Not covered	<p>Drugs listed on Wellmark's Blue Rx Complete Drug List are covered. Drugs not on this Drug List are not covered.</p> <p>1 <u>copay</u> for 30-day supply.</p> <p>3 <u>copays</u> for 90-day supply (Retail and Mail order maintenance).</p> <p><u>Specialty drugs</u> are covered only when obtained through the CVS Specialty Pharmacy Program.</p> <p>See wellmark.com/prescriptions for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your plan.</p> <p>-----None-----</p> <p>-----None-----</p> <p>For <u>emergency medical conditions</u> treated out-of-network, you may be balance billed.</p> <p>For covered non-emergent situations, out-of-network ambulance services are NOT reimbursed at the in-network level. The member may be balance billed for any out-of-network service.</p> <p>-----None-----</p> <p>-----None-----</p> <p>-----None-----</p>
	Tier 2	\$30 <u>copay</u> per prescription	Not covered	
	Tier 3	\$60 <u>copay</u> per prescription	Not covered	
	Tier 4	\$120 <u>copay</u> per prescription	Not covered	
	Specialty drugs	Preferred: \$175 <u>copay</u> per prescription Non-Preferred: \$225 <u>copay</u> per prescription	Not covered	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not covered	
	<u>Physician/surgeon</u> fees	20% <u>coinsurance</u>	Not covered	
<p>If you need immediate medical attention</p>	<u>Emergency room care</u>	\$300 <u>copay</u> per visit for facility and physician(s) combined	\$300 <u>copay</u> per visit for facility and physician(s) combined	
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	<u>Urgent care</u>	\$25 <u>copay</u> per provider per date of service	Not covered	
<p>If you have a hospital stay</p>	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not covered	
	<u>Physician/surgeon</u> fees	20% <u>coinsurance</u>	Not covered	

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242. You can find your Coverage Manual at sbccmfinder.wellmark.com.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$25 <u>copay</u> per provider per date of service Facility: 20% <u>coinsurance</u>	Not covered	-----None-----
	Inpatient services	20% <u>coinsurance</u>	Not covered	-----None-----
If you are pregnant	Office visits	No charge	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for preventive services. For any in-network services that fall outside of routine obstetric care, the office visit benefits shown above may apply.
	Childbirth/delivery professional services	No charge	Not covered	Benefits shown reflect OB/GYN practitioner services which are typically globally billed at time of delivery for pre-natal, post-natal and delivery services.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not covered	-----None-----
	Home health care	20% <u>coinsurance</u>	Not covered	-----None-----
	Rehabilitation services	Office: \$25 PCP/\$50 Non-PCP <u>copay</u> Facility: 20% <u>coinsurance</u>	Not covered	\$25 <u>copay</u> applies to in-network Physical and Occupational Therapists and Speech Language Pathologists. <u>Copay</u> is applied per provider per date of service.
If you need help recovering or have other special health needs	Habilitation services	Office: \$25 PCP/\$50 Non-PCP <u>copay</u> Facility: 20% <u>coinsurance</u>	Not covered	\$25 <u>copay</u> applies to in-network Physical and Occupational Therapists and Speech Language Pathologists. <u>Copay</u> is applied per provider per date of service.
	Skilled nursing care	20% <u>coinsurance</u>	Not covered	-----None-----
	Durable medical equipment	20% <u>coinsurance</u>	Not covered	Pharmacy durable medical equipment (DME) purchased at a retail pharmacy will be subject to your medical DME cost share.
	Hospice services	20% <u>coinsurance</u>	Not covered	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242. You can find your Coverage Manual at sbccmfinder.wellmark.com.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If your child needs dental or eye care	Children's eye exam	\$50 copay per provider per date of service	Not covered	One routine vision exam per calendar year.
	Children's glasses	Not covered	Not covered	-----None-----
	Children's dental check-up	Not covered	Not covered	-----None-----

#0 For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242. You can find your Coverage Manual at sbccmfinder.wellmark.com.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Custodial care - in home or facility
- Dental care - Adult
- Dental check-up
- Extended home skilled nursing
- Glasses
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion
- Applied Behavior Analysis therapy-covered through age 18 subject to annual limits
- Bariatric surgery
- Chiropractic care (12 visits per calendar year)
- Infertility treatment (excludes some services)
- Private-duty nursing - short term intermittent home skilled nursing
- Routine eye care - Adult (one vision exam per calendar year)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, you can contact: Wellmark at 1-800-524-9242, Iowa Insurance Division at 515-281-5705, or Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

_____ To see examples of how this plan might cover costs for a sample medical situation, see the next page.

Wellmark Health Plan of Iowa, Inc. is an Independent Licensee of the Blue Cross and Blue Shield Association.

This contains only a partial description of the benefits, limitations, exclusions and other provisions of the health care plan. It is not a contract or policy. It is a general overview only. It does not provide all the details of coverage, including benefits, exclusions, and policy limitations. In the event there are discrepancies between this document and the Coverage Manual, Certificate, or Policy, the terms and conditions of the Coverage Manual, Certificate, or Policy will govern.

About These Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$1,000
- PCP copayment \$25
- Hospital(facility) coinsurance 20%
- Other no charge No Charge

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (ultrasounds and blood work)
 Specialist visit (anesthesia)

Total Example Cost \$12,700

In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,060

Managing Joe's type 2 Diabetes

(a years of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$1,000
- Specialist copayment \$50
- Hospital(facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)
 Diagnostic tests (blood work)
 Prescription drugs
 Durable medical equipment (glucose meter)

Total Example Cost \$5,600

In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$50
<u>Copayments</u>	\$1,300
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,370

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$1,000
- Specialist copayment \$50
- Hospital(facility) copayment \$300
- Other coinsurance 20%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)
 Diagnostic test (x-ray)
 Durable medical equipment (crutches)
 Rehabilitation services (physical therapy)

Total Example Cost \$2,800

In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,640

The amounts shown in the maternity claim example above are based on amounts using a single per person deductible. Some plans may actually apply a two-person or family deductible to maternity services for the mother and newborn baby.

The plan would be responsible for the other costs of these EXAMPLE covered services.



Primary 1000 POS



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.wellmark.com or call 1-800-524-9242. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-524-9242 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: \$1,000 person/ \$3,000 family per calendar year. Out-of-Network: \$1,000 person/ \$3,000 family per calendar year.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network well-child care, in-network preventive care, in-network physician maternity care, certain in-network outpatient hospital x-ray/lab, in-network prosthetic limbs and services subject to health and drug card copayments are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No. There are no other deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Health In-Network: \$2,000 person/ \$4,000 family per calendar year. Health Out-Of-Network: \$2,000 person/ \$4,000 family per calendar year. Drug Card: \$2,000 person/ \$4,000 family per calendar year. The In-Network health and drug card out-of-pocket maximum amounts accumulate together.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why this Matters:
Will you pay less if you use a network provider?	Yes. See www.wellmark.com or call 1-800-524-9242 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 copay per provider per date of service	40% coinsurance	Primary Care Practitioners (PCP) are defined as General and Family Practice, Internal Medicine, OB/GYN, Pediatricians, Nurse Practitioners and PAs.
	Specialist visit	\$50 copay per provider per date of service	40% coinsurance	Applies to Non-PCP providers. \$25 copay per provider per date of service for in-network chiropractic services.
	Preventive care/screening/immunization	No charge	40% coinsurance	One preventive exam and one gynecological exam per calendar year. One mammogram per calendar year. Well-child care is covered to age 7. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.

#5 For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242. You can find your Coverage Manual at sbccmfinder.wellmark.com.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a test	<u>Diagnostic test</u> (x-ray, blood work) Imaging (CT/PET scans, MRIs)	Independent Lab: \$25 <u>copay</u> per <u>provider</u> per date of service Facility: 20% <u>coinsurance</u> 20% <u>coinsurance</u>	40% <u>coinsurance</u> 40% <u>coinsurance</u>	Waive <u>copay</u> on <u>in-network</u> independent lab services for mental health/substance abuse. For a test in a <u>provider's</u> office or clinic, your cost is included in the cost-share listed above. -----None-----
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.wellmark.com/prescriptions .	Tier 1 Tier 2 Tier 3 Tier 4 Specialty drugs	\$15 <u>copay</u> per prescription \$30 <u>copay</u> per prescription \$60 <u>copay</u> per prescription \$120 <u>copay</u> per prescription Preferred: \$175 <u>copay</u> per prescription Non-preferred: \$225 <u>copay</u> per prescription	Not covered Not covered Not covered Not covered Not covered	Drugs listed on Wellmark's Blue Rx Complete Drug List are covered. Drugs not on this Drug List are not covered. 1 <u>copay</u> for 30-day supply. 3 <u>copays</u> for 90-day supply (Retail and Mail order maintenance). <u>Specialty</u> drugs are covered only when obtained through the CVS Specialty Pharmacy Program. See wellmark.com/prescriptions for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your plan.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center) <u>Physician/surgeon</u> fees	20% <u>coinsurance</u> 20% <u>coinsurance</u>	40% <u>coinsurance</u> 40% <u>coinsurance</u>	-----None----- -----None-----

#6 For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242. You can find your Coverage Manual at sbccmfinder.wellmark.com.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	<u>Emergency room care</u>	\$300 <u>copay</u> per visit for facility and physician(s) combined	\$300 <u>copay</u> per visit for facility and physician(s) combined	For <u>emergency medical conditions</u> treated out-of- <u>network</u> , you may be balance billed.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	For covered non-emergent situations, out-of- <u>network</u> ambulance services are NOT reimbursed at the in- <u>network</u> level. The member may be balance billed for any out-of- <u>network</u> service.
If you have a hospital stay	<u>Urgent care</u>	\$25 <u>copay</u> per provider per date of service	40% <u>coinsurance</u>	Waive cost-share on out-of- <u>network</u> services for mental health/substance abuse.
	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
If you need mental health, behavioral health, or substance abuse services	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	Outpatient services	Office: \$25 <u>copay</u> per provider per date of service Facility: 20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
If you are pregnant	Office visits	No Charge	40% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for preventive services. For any in- <u>network</u> services that fall outside of routine obstetric care, the office visit benefits shown above may apply.
	Childbirth/delivery professional services	No Charge	40% <u>coinsurance</u>	Benefits shown reflect OB/GYN practitioner services which are typically globally billed at time of delivery for pre-natal, post-natal and delivery services.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----

#17 For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242. You can find your Coverage Manual at [sbccmfinder.wellmark.com](https://www.wellmark.com/sbccmfinder).

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----	
	<u>Rehabilitation services</u>	Office: \$25 PCP/\$50 non-PCP <u>copay</u> Facility: 20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Copay</u> is applied per <u>provider</u> per date of service. \$25 <u>copay</u> applies to <u>in-network</u> Physical and Occupational Therapists and Speech Language Pathologists.	
	<u>Habilitation services</u>	Office: \$25 PCP/\$50 non-PCP <u>copay</u> Facility: 20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Copay</u> is applied per <u>provider</u> per date of service. \$25 <u>copay</u> applies to <u>in-network</u> Physical and Occupational Therapists and Speech Language Pathologists.	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----	
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pharmacy <u>durable</u> medical equipment (DME) purchased at a retail pharmacy will be subject to your medical DME cost share.	
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.	
	If your child needs dental or eye care	Children's eye exam	\$50 <u>copay</u> per <u>provider</u> per date of service	Not covered	One routine vision exam per calendar year. Must be performed by an <u>in-network</u> provider.
		Children's glasses	Not covered	Not covered	-----None-----
		Children's dental check-up	Not covered	Not covered	-----None-----

#∞ For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242. You can find your Coverage Manual at sbccmfinder.wellmark.com.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Custodial care - in home or facility
- Dental care - Adult
- Dental check-up
- Extended home skilled nursing
- Glasses
- Hearing aids
- Long-term care
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion
- Applied Behavior Analysis therapy-covered through age 18 subject to annual limits
- Bariatric surgery
- Chiropractic care
- Infertility treatment (excludes some services)
- Most coverage provided outside the U.S.
- Private-duty nursing - short term intermittent home skilled nursing
- Routine eye care - Adult (one vision exam per calendar year)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, you can contact: Wellmark at 1-800-524-9242, Iowa Insurance Division at 515-281-5705, or Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

_____ To see examples of how this plan might cover costs for a sample medical situation, see the next page.

Wellmark Health Plan of Iowa, Inc. is an Independent Licensee of the Blue Cross and Blue Shield Association.

This contains only a partial description of the benefits, limitations, exclusions and other provisions of the health care plan. It is not a contract or policy. It is a general overview only. It does not provide all the details of coverage, including benefits, exclusions, and policy limitations. In the event there are discrepancies between this document and the Coverage Manual, Certificate, or Policy, the terms and conditions of the Coverage Manual, Certificate, or Policy will govern.

About These Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$1,000
- PCP copayment \$25
- Hospital(facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,060

Managing Joe's type 2 Diabetes (a years of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$1,000
- Specialist copayment \$50
- Hospital(facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$50
<u>Copayments</u>	\$1,300
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,370

Mia's Simple Fracture (in-network emergency room visit and follow up care)

- The plan's overall deductible \$1,000
- Specialist copayment \$50
- Hospital(facility) copayment \$300
- Other coinsurance 20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,640

The amounts shown in the maternity claim example above are based on amounts using a single per person deductible. Some plans may actually apply a two-person or family deductible to maternity services for the mother and newborn baby.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Dental Plan Benefit Highlights

No Changes

Benefit		
Insurance Provider	Delta Dental of Iowa	
Plan Name	Delta Dental PPO	Delta Dental Premier / Non PPO
Individual Deductible	N/A	N/A
Orthodontic Annual Deductible	\$50	\$50
Diagnostic & Preventive	100% / 0%	100% / 0%
	Routine Cleanings (2 in a benefit period aggregate with period maintenance therapy)	
Routine and Restorative	100% / 0%	80% / 20%
Root Canals (Endodontics)	90% / 10%	80% / 20%
Gum and Bone Diseases (Periodontal)	90% / 10%	80% / 20%
High Cost Restorations (Cast)	80% / 20%	80% / 20%
Dentures and Bridges (Prosthetic)	80% / 20%	80% / 20%
Straighter Teeth (Orthodontics) <i>Adults & Children</i>	50% / 50%	50% / 50%
Calendar Year Maximum <i>(Annual Maximum Carryover – To Go)</i>	\$2,000	



Delta Dental of Iowa

Employee Summary of Covered Services and Benefits

University of Iowa Community Medical Services LLC.

Deductibles, Maximums & Eligibility	Delta Dental PPO SM	Delta Dental Premier [®] / Non Par
- Individual Deductible	N/A	N/A
- Deductible applies to Check-Ups and Teeth Cleaning?	\$0.00	\$0.00
- Benefit Period Maximum	\$2,000	\$2,000
- Eligible children to age	26	26
- Full-time (unmarried) students eligible to age	99	99
- Orthodontic annual deductible	No	No
- Included in Benefit Period Maximum?	Yes	Yes
- Orthodontics: Eligible children to age	26	26
- Orthodontics: Full-time students eligible to age	99	99
- Adult Orthodontics	Yes	Yes
Benefits		
Check-Ups and Teeth Cleaning	0%	0%
(Diagnostic and Preventive Services)		
- Dental Cleaning	<i>2 in a benefit period aggregate with perio maintenance therapy</i>	
- Oral Evaluations	<i>2 in a benefit period</i>	
- Fluoride Applications		
- X-Rays	<i>Bitewings - 2 every 12 months; Full mouth - 1 every 5 years</i>	
- Sealant Applications	<i>1 in a lifetime per permanent 1st and 2nd molars to age 18</i>	
- Space Maintainers	<i>To age 18</i>	
- Periodontal Maintenance Therapy	<i>2 in a benefit period aggregate with dental cleaning</i>	
Cavity Repair and Tooth Extractions	0%	20%
(Routine and Restorative Services)		
- Emergency Treatment		
- General Anesthesia/Sedation		
- Restoration of Decayed or Fractured Teeth		
- Limited Occlusal Adjustments		
- Routine Oral Surgery	<i>Medical is prime for removal of impacted teeth</i>	
- Consultations	<i>2 in a benefit period aggregates with oral evaluations</i>	
- Antibiotic Drug Injections		
- Posterior Composites w/o Alternate Processing		
Root Canals (Endodontic Services)	10%	20%
- Apicoectomy		
- Direct/Indirect Pulp Cap		
- Pulpotomy		
- Retrograde Fillings		
- Root Canal Therapy		
Gum and Bone Diseases (Periodontal Services)	10%	20%
- Conservative Procedures (Non-surgical)	<i>1 every 24 months per quadrant</i>	
- Complex Procedures (Surgical)	<i>1 every 36 months per quadrant</i>	
- Periodontal Appliances	<i>1 every 3 years</i>	
High Cost Restorations (Cast Restorations)	20%	20%
- Cast Restorations		
- Crowns		
- Inlays		
- Onlays		
- Post and Cores		
- Recementing Crowns/Inlays/Onlays		
Dentures and Bridges (Prosthetic Services)	20%	20%
- Bridges		
- Dentures		
- Repairs and Adjustments		
- Recementing of Bridges		
- Implants w/o Alternate Processing		
Straighter Teeth (Orthodontics)	50%	50%
Additional Options		
-Annual Maximum Carryover - To GoSM	<i>Included</i>	<i>Included</i>

This dental plan includes the Annual Maximum Carryover – To GoSM for carryover of unused Benefit Period Maximums to the next benefit contract year. Please refer to your dental benefits document for details.

The percentage shown is the coinsurance amount that is the responsibility of the Covered Person.

This is a general description of coverage. It is not a statement of your contract. Actual coverage is subject to terms and conditions specified in the benefits document itself and enrollment regulations in force when the benefits become effective. Certain exclusions and limitations apply. Please refer to your dental benefits document for details.

To GoSM

Increase Your Annual Benefit Maximum



To Go allows you to carry over any unused annual maximums from one year to the next. This benefit offers more flexibility and helps you plan for more extensive and costly dental treatments in subsequent years.

How To Go Works

For example, if your plan has an annual maximum of \$2,000, here is how you can use To Go.

Year 1		Year 2		Year 3	
Annual Benefit Maximum	\$2,000	Annual Benefit Maximum	\$2,000	Annual Benefit Maximum	\$2,000
Eligible Benefit Used	\$500	To Go Benefit from Year 1	\$1,500	To Go Benefit from Year 2	\$2,000
Unused Annual Benefit Maximum	\$1,500	Year 2 Annual Benefit Maximum	\$3,500	Year 3 Annual Benefit Maximum	\$4,000
To Go - Annual Maximum Carryover (for use in year 2)	\$1,500	Eligible Benefit Used	\$500	Eligible Benefit Used	\$1,500
		Unused Annual Benefit Maximum	\$3,000	Unused Annual Benefit Maximum	\$2,500
		To Go - Annual Maximum Carryover (for use in year 3)	\$2,000*	To Go - Annual Maximum Carryover (for use in year 4)	\$2,000*

Questions?

If you have any questions about your dental benefits, visit the Delta Dental website at deltadentalia.com and log into the Member Connection or you can call customer service at 800-544-0718.

To Go Guidelines:

1. You must be covered under the plan for the full benefit plan year, with coverage for major services, and not subject to any benefit waiting periods for these services.
2. You must have submitted at least one claim during the benefit plan year that would apply to your annual maximum.
3. The carryover amount may not exceed the amount of the regular annual maximum and the total combined annual maximum may not exceed twice the regular annual maximum.

* The To Go - Annual Maximum Carryover amount cannot exceed the annual benefit maximum.

Voluntary Vision Plan Benefit Highlights

No Changes

Benefit	In-Network Member Benefits
Insurance Company	VSP
WellVision Exam	\$10 Copay Frequency: Every calendar year
Prescription Glasses	\$25 Copay (Applies to frame or lenses)
Frame Allowance	\$130 allowance for a wide selection of frames \$150 allowance for featured frame brands 20% savings on the amount over your allowance Frequency: Every calendar year
Lenses Single Vision Lined Bifocal Lined Trifocal Polycarbonate for dependent children	Included in Prescription Glasses Frequency: Every calendar year
Lens Enhancements Standard progressive lenses Premium progressive lenses Custom progressive lenses Average savings 20-25% on other lens enhancements	\$55 Copay \$95 - \$105 Copay \$150 - \$175 Copay Frequency: Every calendar year
Contacts (instead of glasses) \$130 allowance for contacts Contact lens exam (fitting and evaluation)	N/A Up to \$60 Copay

Life is
better in
focus.™

Get access to the best in eye care and eyewear with UNIVERSITY OF IOWA COMMUNITY MEDICAL SERVICES, LLC. and VSP® Vision Care.



Why enroll in VSP? As a member, you'll receive access to care from great eye doctors, quality eyewear, and the affordability you deserve, all at the lowest out-of-pocket costs.

You'll like what you see with VSP.

- **Value and Savings.** You'll enjoy more value and the lowest out-of-pocket costs.
- **High Quality Vision Care.** You'll get the best care from a VSP network doctor, including a WellVision Exam®—the most comprehensive exam designed to detect eye and health conditions. Plus, when you see a VSP network doctor, your satisfaction is guaranteed.
- **Choice of Providers.** The decision is yours to make—choose a VSP network doctor or any out-of-network provider.
- **Great Eyewear.** It's easy to find the perfect frame at a price that fits your budget.

Using your VSP benefit is easy.

- **Create an account at vsp.com.** Once your plan is effective, review your benefit information.
- **Find an eye doctor who's right for you.** Visit vsp.com or call 800.877.7195.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on vsp.com.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like bebe®, Calvin Klein, Cole Haan, Flexon®, Lacoste, Nike, Nine West, and more.¹ Visit vsp.com to find a Premier Program location that carries these brands. Plus, save up to 40% on popular lens enhancements.² Prefer to shop online? Check out all of the brands at eyeconic.com®, VSP's preferred online eyewear store.

Enroll in VSP today.
You'll be glad you did.
Contact us. 800.877.7195
vsp.com

Your VSP Vision Benefits Summary



UNIVERSITY OF IOWA COMMUNITY MEDICAL SERVICES, LLC. and VSP provide you with an affordable eye care plan.

VSP Coverage Effective Date: 01/01/2018

VSP Provider Network: VSP Choice

Benefit	Description	Copay	Frequency
Your Coverage with a VSP Provider			
WellVision Exam	<ul style="list-style-type: none"> Focuses on your eyes and overall wellness 	\$10	Every calendar year
Prescription Glasses		\$25	See frame and lenses
Frame	<ul style="list-style-type: none"> \$130 allowance for a wide selection of frames \$150 allowance for featured frame brands 20% savings on the amount over your allowance 	Included in Prescription Glasses	Every calendar year
Lenses	<ul style="list-style-type: none"> Single vision, lined bifocal, and lined trifocal lenses Polycarbonate lenses for dependent children 	Included in Prescription Glasses	Every calendar year
Lens Enhancements	<ul style="list-style-type: none"> Standard progressive lenses Premium progressive lenses Custom progressive lenses Average savings of 20-25% on other lens enhancements 	\$55 \$95 - \$105 \$150 - \$175	Every calendar year
Contacts (instead of glasses)	<ul style="list-style-type: none"> \$130 allowance for contacts; copay does not apply Contact lens exam (fitting and evaluation) 	Up to \$60	Every calendar year
Extra Savings	Glasses and Sunglasses <ul style="list-style-type: none"> Extra \$20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. 		
	Retinal Screening <ul style="list-style-type: none"> No more than a \$39 copay on routine retinal screening as an enhancement to a WellVision Exam 		
	Laser Vision Correction <ul style="list-style-type: none"> Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities 		

Your Coverage with Out-of-Network Providers

Get the most out of your benefits and greater savings with a VSP network doctor. Your coverage with out-of-network providers will be less or you'll receive a lower level of benefits. Visit vsp.com for plan details.

Exam	up to \$45	Lined Bifocal Lenses	up to \$50	Progressive Lenses	up to \$50
Frame	up to \$70	Lined Trifocal Lenses	up to \$65	Contacts	up to \$105
Single Vision Lenses	up to \$30				

VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

Contact us. **800.877.7195** | vsp.com

1. Brands/Promotion subject to change.
 2. Savings based on network doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Available only through VSP network doctors to VSP members with applicable plan benefits. Ask your VSP network doctor for details.

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Group Life and AD&D Insurance Benefit Highlights

No Changes

Benefit	Coverage Amount
Insurance Provider	the mgis companies (Sun Life Assurance Company of Canada)
Basic Life Insurance	1 times annual salary to a maximum of \$125,000
Accidental Death & Dismemberment	Equal to Basic Life Insurance
Coverage Reduction	65% at age 65 45% at age 70 30% at age 75 20% at age 80 15% at age 85 Benefits terminate at retirement.
Conversion Option	Included

Voluntary Life Insurance Benefit Highlights

No Changes

Benefit	Employee Coverage Amount
Insurance Provider	the mgis companies (Sun Life Assurance Company of Canada)
Employee Supplemental Life Insurance	Amounts up to \$150,000 - Increments of \$10,000 Amounts in excess of \$150,000 – Increments of \$50,000 to a maximum of five times annual salary or \$500,000
Guarantee Issue Limit	\$150,000 (if coverage applied for within 31 days of eligibility)
Coverage Reduction	50% at age 70

Spouse Supplemental Life Insurance	Increments of \$5,000 to a maximum of \$250,000 (cannot exceed 50% of the employee's benefit)
Guarantee Issue Limit	\$30,000 (if coverage applied for within 31 days of eligibility)
Coverage Reduction	50% at age 70

Child(ren) Supplemental Life Insurance	Choice of \$2,500; \$5,000; \$7,500; or \$10,000
Age 6 months to 21 years (25 years for FT Student)	
Guarantee Issue Limit	Entire amount (if coverage applied for within 31 days of eligibility)

Proof of good health is required if you want to enroll after initial eligibility.

Group Long Term Disability Income Benefit Highlights

No Changes

Benefit	Coverage Amount
Insurance Provider	the mgis companies (Sun Life Assurance Company of Canada)
Monthly Benefit	60% of covered earnings
Maximum Benefit	Up to \$10,000 per month
Waiting Period	90 days
Pre-Existing Conditions	3 / 3 / 12
Benefit Duration	Age 65
Conversion Option	Included

Voluntary Short Term Disability Income Benefit Highlights

No Changes

Benefit	Coverage Amount
Insurance Provider	The Hartford
Weekly Benefit	67% of covered earnings
Maximum Benefit	Up to \$1,000 per week
Benefits Payable	15 th day accident 15 th day sickness
Pre-Existing Conditions	6 / 6 / 12
Benefit Duration	Recovery or 11 weeks

Proof of good health is required if you want to enroll after initial eligibility.

Flexible Spending Accounts (FSA) Pre-Tax Benefit Options

<p style="text-align: center;">\$550 Carryover</p> <p>Up to \$550 of your 2021 election will not be subject to the “use it or lose it” rule. This carryover allows you to spend up to \$550 in 2022 if you don’t use it in 2021.</p> <p><i>One debit card is included. You may request one additional debit card at no cost. Keep your existing debit card if you are currently enrolled with Kabel. Existing Flex participants will not get a new debit card for 2021.</i></p>	<p>Group Health Premiums</p> <p>Automatic Enrollment for Pre-Tax Premiums</p> <p><i>If you DO NOT want your Medical, Dental, and Vision premiums to be pre-taxed, you MUST notify Human Resources.</i></p>
	<p>Unreimbursed Medical Expenses</p> <ul style="list-style-type: none"> ◆ Medical/Rx, Dental, Vision, & Other Health Expenses ◆ Deductibles, Copays, and Coinsurance ◆ Reimbursement from Day 1 ◆ \$2,750 Annual Maximum ◆ Debit Card
	<p>Dependent Care Expenses</p> <ul style="list-style-type: none"> ◆ Dependent Children < Age 13 (unless disabled) ◆ Reimbursement after payroll deduction ◆ \$5,000 Annual Maximum (Joint & HH)

Flex Plan Overview

	\$3,000	\$3,000	
		(200)	Monthly Gross Income
		(400)	Family Medical (Pre-Tax)
		2,400	Dependent Care (Pre-Tax)
		(450)	Net Gross Income
Federal Tax	(450)	(360)	Federal Tax
State Tax	(150)	(120)	State Tax
FICA	(230)	(184)	FICA
Family Medical	(200)		
Dependent Care	(400)		
Net Income	\$1,570	\$1,736	Net Income

Flex Increased Income \$166 per Month = \$1,992 Annually!

Know Your Eligible and Ineligible Expenses

Eligible Expenses

Baby/Child to age 13

- Lactation consultant
- Lead-based paint removal*
- Special formula*
- Tuition: special school/teacher for disability or learning disability
- Well baby/well child care

Dental

- Dental x-rays
- Dentures and bridges
- Exams and teeth cleaning
- Extractions and fillings
- Oral surgery
- Orthodontia
- Periodontal services

Eyes

- Eye exams
- Eyeglasses and contact lenses
- Laser eye surgeries
- Prescription sunglasses
- Radial keratotomy

Hearing

- Hearing aids and batteries
- Hearing exams

Lab Exams/Tests

- Blood tests and Metabolism tests
- Body scans
- Cardiograms
- Laboratory fees
- X-rays

Medications

- Insulin
- OTC drugs
- Prescription drugs

Medical Equipment/Supplies

- Air purification equipment*
- Arches and other orthotic inserts
- Contraceptive devices
- Crutches, walkers, wheel chairs
- Exercise equipment*
- Hospital beds*
- Mattresses*
- Medic alert bracelet or necklace
- Nebulizers
- Orthopedic shoes*
- Oxygen
- Post-mastectomy clothing
- Prosthetics
- Syringes
- Wigs*

Obstetrics

- Doula*
- Lamaze class
- OB/GYN exams
- OB/GYN prepaid maternity fees (reimbursable after date of birth)
- Pre- and post-natal treatments

Practitioners

- Allergist
- Chiropracter
- Christian Science Practitioner
- Dermatologist
- Homeopath
- Naturopath*
- Osteopath
- Physician
- Psychiatrist or Psychologist

Therapy

- Alcohol and Drug addiction
- Counseling (must be treating a medical condition)
- Exercise programs*
- Hypnosis*
- Massage*
- Occupational
- Physical
- Smoking cessation programs
- Speech
- Weight loss programs

Medical Procedures/Services

- Acupuncture
- Alcohol and drug/substance abuse (inpatient treatment and outpatient care)
- Ambulance
- Fertility enhancement and treatment
- Hair loss treatment*
- Hospital services
- Immunization
- In vitro fertilization
- Personal trainers*
- Physical examination (not employment-related)
- Reconstructive surgery (due to a congenital defect, accident or medical treatment)
- Service animals
- Sterilization/sterilization reversal
- Transplants (including organ donor)
- Transportation*

This list is not meant to be all-inclusive, as other expenses not specifically mentioned may also qualify. Also, expenses marked with an asterisk (*) are "potentially eligible expenses" that require a note of medical necessity from your health care provider to qualify for reimbursement. For additional information, check your Summary Plan Document or contact isolved Benefit Services.

Over-the-Counter (OTC) Medicines, purchased on or after January 1, 2020, were reinstated with the passage of the CARES Act (COVID-3 Stimulus Bill) for HSAs, FSAs and Archer MSAs (unless your plan excludes OTC items). OTC items can be purchased with funds from eligible accounts without needing a prescription. Additionally, the bill expanded OTC items to include menstrual care products.

Eligible Over-the-Counter Items

Note: Product categories are listed in bold face; common examples of products are listed in regular face.

The following is a high-level list of over-the-counter (OTC) items that are not medicine or drugs and are eligible for purchase with Health Care FSA dollars. You can use your benefits card for these items

Antiseptics, wound cleaners

Alcohol, peroxide, Epsom salt

Baby electrolytes

Pedialyte, Enfalyte

Denture adhesives, repair and cleansers

PoliGrip, Benzodent, Efferdent

Diabetes testing and aids

Insulin, Ascencia, One Touch, Diabetic Tussin, insulin syringes, glucose products

Sunscreen (SPF 15 and over)

Diagnostic products

Thermometers, blood pressure monitors, cholesterol testing

Elastics/athletic treatments

ACE, Futuro, elastic bandages, braces, hot/cold therapy, orthopedic supports, rib belts

Eye care

Contact lens care

Family planning

Pregnancy and ovulation kits

First aid dressings and supplies

Band Aid, 3M Nexcare, non-sport tapes

Hearing aid/medical batteries

Incontinence products

Attends, Depend, GoodNites for juvenile incontinence

Feminine hygiene products

Sanitary pads, tampons, panty liners

Ineligible Expenses

Note: This list is not meant to be all-inclusive

The IRS does not allow the following expenses to be reimbursed the FSA, as they are not prescribed by a physician for a specific ailment.

Contact lens or eyeglass insurance

Electrolysis

Swimming lessons

Cosmetic surgery/procedures

Marriage or career counseling

Sunscreen (SPF less than 15 needs RX)

iSolved[®] Benefit Services

FORMERLY KABEL

KBSFlex MOBILE APP

Check account balances, submit claims, and review resources for your Flexible Spending Account (FSA)

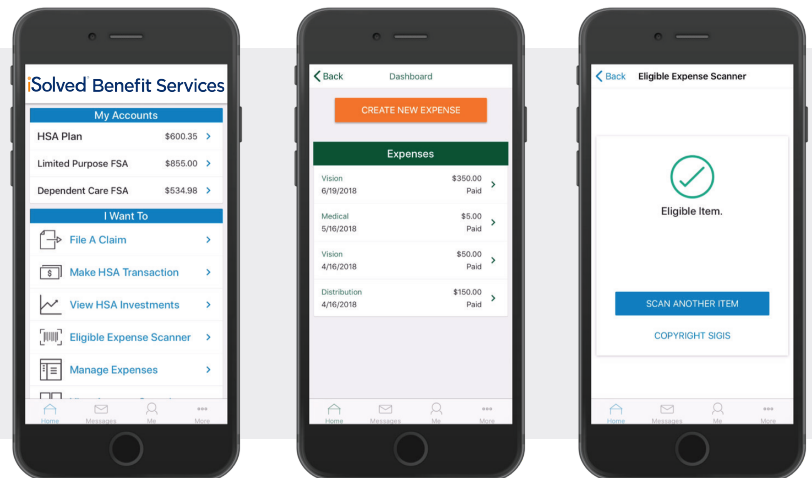
When you enroll in the company-sponsored Flexible Spending Account (FSA), you have a variety of tools and resources available at your fingertips. One of these offerings is the **KBSFlex** mobile app, which allows you to use your mobile device to check health benefit account balances from anywhere at any time.

Download **KBSFlex** as soon as you enroll in the FSA and start using your smartphone or tablet to access your account balance. It's easy to see exactly how much money you have available to spend on qualified health or dependent care expenses at the time of purchase. You can also submit claims for reimbursement and upload receipts using the camera on your mobile device.

There is also an option to set up text message alerts for balance updates and other configurable data.

***KBSFlex** gives you access from anywhere, simplifying the process of making the most out of your FSA funds.*

No sensitive account information is ever stored on your mobile app or device and the highest level of secure encryption is used to protect all transmissions.



The KBSFlex mobile app is available for free on Google Play and the App Store.

As soon as you enroll in the company-sponsored FSA, download **KBSFlex** to start enjoying instant access to your FSA account information, along with a variety of resources, from your mobile device.

Flexible Spending Accounts

REAL SAVINGS. REAL SIMPLE.



Using a Flexible Spending Account (FSA) is a great way to stretch your benefit dollars. You use pre-tax dollars in your FSA to reimburse yourself for eligible out-of-pocket medical and dependent care expenses. That means you can enjoy tax savings with the convenience of a prepaid benefits card. And that makes real sense.

WHAT IS AN FSA?

With an FSA, you elect to have your annual contribution (up to the annual limit set by the IRS) deducted from your paycheck each pay period in equal installments throughout the year. The amount of your pay that goes into an FSA will not count as taxable income, so you will have immediate tax savings. FSA dollars can be used during the plan year to pay for qualified expenses and services. Please check with your employer to see what plans are offered.



A Health FSA allows reimbursement of qualifying out-of-pocket medical expenses.

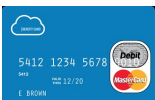


A Dependent Care FSA allows reimbursement of dependent care expenses, such as day care, incurred by eligible dependents.



A Limited Purpose Health FSA is compatible with a Health Savings Account (HSA). A limited FSA only allows reimbursement for preventive care, vision and dental expenses, keeping the employee eligible to contribute to an HSA.

With all FSA account types, you'll receive access to a secure, easy-to-use web portal where you can track your account balance, view your investment accounts and submit requests for reimbursements.



In addition, your plan might offer a convenient prepaid benefits card to make it easy to pay for eligible services and products. When you use the card, payments are automatically withdrawn from your account, so there are no out-of-pocket costs and you likely won't have to submit receipts to verify the purchase. Just swipe the card and go. It's that easy!

Throughout the year, you'll likely find yourself with expenses for yourself and your family that insurance won't cover. By taking advantage of a health care FSA, you can actually reduce your taxable income and reduce your out-of-pocket expenses when you use your FSA to pay for health care services and products you'd purchase anyway.

Benefit Costs - January 1, 2021

Your **medical and prescription drug** and **dental** premiums are illustrated based on 100% Full Time Employee. Eligibility is limited to 50% or greater FTE.

Voluntary Short Term Disability and **Voluntary Vision** are 100% employee paid. Voluntary Short Term Disability will require proof of good health if you want to add or increase after initial eligibility.

Group Life is provided to you at no cost if you are a 50% or greater Full Time Employee. **Voluntary Life** is 100% employee paid (>50% FTE). Voluntary Life will require proof of good health if you want to add or increase at this time.

Group Long Term Disability is provided to you at no cost if you are a 75% or greater Full Time Employee.

You will automatically be enrolled in the portion of the **FSA** to have your Medical, Dental, and Vision premiums be pre-taxed. If you DO NOT want these benefits pre-taxed, you MUST notify Human Resources.

PRN employees are NOT eligible for benefits.

Medical and Prescription Drug Plan		
Primary 1000 HMO		
	Monthly Employee Cost	Deduction Per Pay Period (26)
Single	\$83.69	\$38.62
Family	\$466.68	\$215.39
Primary 1000 POS		
	Monthly Employee Cost	Deduction Per Pay Period (26)
Single	\$168.46	\$77.75
Family	\$678.60	\$313.20

Benefit Costs - January 1, 2021

(continued)

Dental Plan (No Change)		
	Monthly Employee Cost	Deduction Per Pay Period (26)
Single	\$10.83	\$4.99
Family	\$39.00	\$18.00

Voluntary Vision Plan (No Change)	
Monthly Rates	Monthly Employee Cost
Employee Only	\$11.30
Employee + 1 Dependent	\$18.08
Employee + Child(ren)	\$18.46
Family	\$29.76

Voluntary Short Term Disability Income (No Change)
Monthly Employee Cost
\$0.79 per \$10 of benefit

SAMPLE Voluntary Short Term Disability Calculations January 1, 2021

Your Annual Salary	\$30,000
Divided by 52	<u>52</u>
Your Weekly Salary	576.92
Multiplied by STD Benefit Percent	<u>x 0.67</u>
Weekly Benefit (Max = \$1,000)	\$386.54
Divided by 10	<u>10</u>
	\$38.65
Multiplied by STD Rate	<u>x \$0.79</u>
Employee Total Monthly Cost	\$30.53

Benefit Costs - January 1, 2021

(continued)

Voluntary Life Plan (No Change)	
Employee or Spouse Age	Monthly Employee Cost Per \$1,000 of benefit
Under Age 30	\$0.07
Age 30-34	\$0.09
Age 35-39	\$0.14
Age 40-44	\$0.23
Age 45-49	\$0.35
Age 50-54	\$0.55
Age 55-59	\$1.00
Age 60-64	\$1.50
Age 65-69	\$2.24
Age 70+	See Enrollment Form

The employee's premium is based on the age of the employee on the first of the month that premiums are due. The spouse's premium is based on his or her age on the first of the month that premiums are due.

Child(ren) Monthly Rates
\$0.50 per \$2,500 of benefit

SAMPLE Voluntary Life Insurance Calculations January 1, 2021

Employee's Age	45
Amount of Employee Voluntary Life Insurance	\$100,000
Divided by 1000	<u>/ 1000</u>
	100
Multiplied by Life Rate	<u>x \$0.35</u>
Employee Total Monthly Cost	\$35.00

Links

Benefits Landing Page ← New this year!!

<https://northriskpartners.com/uicms/>

- Review benefit presentation recording
- Tip: link is cap sensitive
- Obtain any required forms
- Access employee benefits booklet

Medical and Prescription Drugs

www.wellmark.com

- Find a Doctor or Hospital
- See the Wellmark Drug List
- Register for myWellmark
 - View the status of your claims
 - Run a report showing your out-of-pocket health care spending
 - Check deductible balances
 - View prescriptions you've filled
 - Check drug interactions and compare prescription prices
 - Research health conditions
 - Order additional ID cards
- ❖ **Wellmark.com/GoMobile!**

Dental

www.deltadentalia.com

- Find a Dentist

Vision

www.vsp.com

FSA

www.isolvedbenefitservices.com/kabel

- Check flex account balance
- Upload a claim for reimbursement
- Sign up for Direct Deposit
- ❖ Search for **KBSFlex** in your mobile app store

What Happens Next?

- ❑ Medical and Prescription Drug Plan: Annual Open Enrollment for 2021.
 - ❑ Due to the new dual plan offering, **all eligible employees are required to complete the 2021 Medical Plan Selection** form. This form is included as the last page of your packet or can be downloaded from our open enrollment landing page.
 - ❑ If you are newly enrolling or making enrollment changes (ie. adding or removing dependents) complete a Wellmark enrollment form to make changes or to enroll. This form may be obtained on our open enrollment landing page.
 - ❑ **Please show your new ID card to your medical providers and pharmacists beginning January 1, 2021.**

- ❑ Dental Plan: Annual Open Enrollment for 2021. An enrollment form is not required if you do not make changes to your current medical coverage. Complete a Delta Dental enrollment form to make changes or to enroll. This form can be located on our open enrollment landing page.

- ❑ Voluntary Vision: Annual Open Enrollment for 2021. No forms are needed to continue your same coverage. Complete a VSP enrollment form to make changes or to enroll. This form can be located on our open enrollment landing page.

- ❑ Group Life / AD&D / LTD: You are already enrolled. To ensure your beneficiary designation is accurate, you may complete a new Sun Life Beneficiary Designation form. This form can be located on our open enrollment landing page.

- ❑ Voluntary Life and Dependent Life: Complete an MGIS voluntary enrollment form and a Sun Life Evidence of Insurability to purchase new coverage or increase your current benefit. These forms can be located on our open enrollment landing page.

- ❑ Voluntary Short Term Disability Income: Complete a Hartford enrollment form and a Hartford Evidence of Insurability to purchase new coverage. These forms can be located on our open enrollment landing page.

- ❑ 401(k): Complete an Elective Deferral Form to change your current contribution. You may update your beneficiary. Please contact your HR team for the proper forms for your 401(k).

- ❑ Flexible Spending Accounts: Annual Enrollment for 2021. **You must return a completed iSolved enrollment form to participate in the flex plan for 2021.** This form is included at the back of your packet or can be located on our open enrollment landing page. Reminder: If your debit card has not expired, keep it.



Return your required forms early
(by Monday, November 16th) to be entered
in a drawing for one of two \$50 giveaways!!

Return completed forms to Sophia Chamberlain (smchamberlain@uihealthsystem.org).
Reminder: Medical plan selection form is required this year.

No later than **Monday, November 23rd**!
Forms may be returned electronically (e-mailed)!
Questions???

Please contact our dedicated account team with
North Risk Partners - Bernie Lowe & Associates.



Contact For:

- Group Benefit Questions
- Renewal Notifications
- Coverage/Carrier Questions
- Benefit Strategy Collaboration

Lacey Anderson

Sr. Account Manager – Employee Benefits
Grinnell
Phone: (641) 260-8301
Fax: (641) 260-8302
lacey.anderson@northriskpartners.com



Contact For:

- Group Benefit Questions
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Linda Lowe

Sr. Account Manager – Employee Benefits
Grinnell
Phone: (641) 260-8301
Fax: (641) 260-8302
linda.lowe@northriskpartners.com

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, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_c ont.aspx Phone: 916-440-5676
ALASKA – Medicaid	COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	FLORIDA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131	Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840
INDIANA – Medicaid	MINNESOTA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	MISSOURI – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	MONTANA – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KENTUCKY – Medicaid	NEBRASKA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	NEVADA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcnp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	NEW HAMPSHIRE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/oi/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

<p>NEW JERSEY – Medicaid and CHIP</p> <p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710</p>	<p>SOUTH DAKOTA - Medicaid</p> <p>Website: http://dss.sd.gov Phone: 1-888-828-0059</p>
<p>NEW YORK – Medicaid</p> <p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>	<p>TEXAS – Medicaid</p> <p>Website: http://gethipptexas.com/ Phone: 1-800-440-0493</p>
<p>NORTH CAROLINA – Medicaid</p> <p>Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100</p>	<p>UTAH – Medicaid and CHIP</p> <p>Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669</p>
<p>NORTH DAKOTA – Medicaid</p> <p>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825</p>	<p>VERMONT– Medicaid</p> <p>Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427</p>
<p>OKLAHOMA – Medicaid and CHIP</p> <p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>	<p>VIRGINIA – Medicaid and CHIP</p> <p>Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282</p>
<p>OREGON – Medicaid</p> <p>Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075</p>	<p>WASHINGTON – Medicaid</p> <p>Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022</p>
<p>PENNSYLVANIA – Medicaid</p> <p>Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462</p>	<p>WEST VIRGINIA – Medicaid</p> <p>Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)</p>
<p>RHODE ISLAND – Medicaid and CHIP</p> <p>Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)</p>	<p>WISCONSIN–Medicaid and CHIP</p> <p>Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002</p>
<p>SOUTH CAROLINA – Medicaid</p> <p>Website: https://www.scdhhs.gov Phone: 1-888-549-0820</p>	<p>WYOMING – Medicaid</p> <p>Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269</p>

To see if any other states have added a premium assistance program since July 31, 2020, 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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)



Wellmark Blue Cross and Blue Shield of Iowa and Wellmark Health Plan of Iowa, Inc. are independent licensees of the Blue Cross and Blue Shield Association.

Women's Health and Cancer Rights Act Notice

This notice is being provided on behalf of the following entities:

Wellmark, Inc. doing business as Wellmark Blue Cross and Blue Shield of Iowa

Wellmark Health Plan of Iowa, Inc.

Women's Health and Cancer Rights Act (WHCRA)

This notice informs you of the federal regulation that requires all health plans that cover mastectomies to also cover reconstruction of the removed breast.

For members receiving mastectomy-related benefits, coverage will be provided, in a manner determined in consultation with the attending physician and 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;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductible and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you have any questions or concerns, please contact the Customer Service phone number listed on your Wellmark identification card.

Wellmark Blue Cross and Blue Shield of Iowa
Wellmark Health Plan of Iowa, Inc.
PO Box 9232
Des Moines. IA 50306-9232

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Updated October 21, 2020

Data taken from: OMB No. 1210-0149

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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 University of Iowa Community Medical Services 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 are offered health coverage from University of Iowa Community Medical Services that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in University of Iowa Community Medical Services'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 University of Iowa Community Medical Services does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of the plan from University of Iowa Community Medical Services that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Note:

If you purchase a health plan through the Marketplace instead of accepting health coverage offered by University of Iowa Community Medical Services, 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 University of Iowa Community Medical Services, please check your summary plan description or contact:

Your Contact is:	Emily Puhl, HR with UIHV
Phone:	319-337-8522 ex 1150
Email:	puhl@uihealthsystem.org

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.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Updated October 21, 2020

Data taken from: OMB No. 1210-0149

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by University of Iowa Community Medical Services. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name:	University of Iowa Community Medical Services, LLC.
4. Employer Identification Number (EIN):	42-1454252
6. Employer Phone Number:	319-337-8522
5. Employer Address:	2346 Morman Trek Blvd, Suite 1500
7. City:	Iowa City
8. State:	Iowa
9. ZIP code:	52246
8. Who can we contact about employee health coverage at this job?	Emily Puhl, HR University of Iowa Community Medical Services
9. Phone number (if different from above):	319-337-8522
10. Email address:	puhl@uihealthsystem.org

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to: **Some Employees.** Eligible employees are: Active employees who are on the employer's payroll and meet their employer's definition of an eligible employee (typically classified as a minimum of 50% FTE) are considered eligible. PRN employees are not eligible for coverage.
- With respect to dependents; **We do offer coverage.** Eligible dependents are: The covered employee's spouse by legal marriage or common law marriage; and the eligible dependent child(ren) of the employee or spouse who is(are) a natural child, a natural child a court orders to be covered, a stepchild, a foster child, a legally adopted child (or a child placed with the employee for adoption), or a child for whom the employee has been appointed legal guardian. Coverage for unmarried domestic partners includes both same and opposite sex domestic partners. Domestic relationship has to be in effect for 12 months prior to coverage.

[] If checked, the coverage University of Iowa Community Medical Services, LLC. offers meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

NOTE: Even if your employer coverage is intended to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.



EASY ACCESS TO YOUR ACCOUNT

Taking charge of your future starts with knowing where you stand — that's why your Transamerica account is built for easy access. You can review the current status of your account, make changes, and access tools to help personalize your retirement strategy.



ONLINE ACCESS
transamerica.com/portal/home

GETTING STARTED

Step 1: Click **Create an account** in the top-right corner.

Step 2: On the next page, you'll be prompted to enter your Social Security number and go through a verification process.

ONCE YOU'RE IN

From the left-hand menu, scroll over the five tabs — **Home, Review, Manage, Are You OnTrack[®], and Resource Center** — and select an option from the drop-down lists.

CHECK ACCOUNT BALANCE

- Balance automatically appears on the overview page
- For account balance by fund, click "**Balance**"

REVIEW INVESTMENT PERFORMANCE

- To get performance and fee details for all the funds in your plan, click "**Fund and Fee Information**" under the Review tab

PLAN YOUR RETIREMENT OUTLOOK[®]

- Our planning tools can help you develop and analyze your strategy across all your retirement accounts — inside and outside your plan

CHANGE CONTRIBUTION AMOUNT

- To choose or change your contribution amount and sign up for annual, automatic increases, click "**Contributions**" under the **Manage** tab

You should evaluate your ability to continue the auto-increase service in the event of a prolonged market decline, unexpected expenses, or an unforeseeable emergency.

TRANSFER BETWEEN INVESTMENT OPTIONS (CURRENT ASSETS)

- To transfer balances between individual or groups of funds, click "**Transfers**" under the **Manage** tab
- To change your overall investment mix, click "**Current Investments**" under the **Manage** tab

GET LOAN DETAILS

- To review loan status and get payoff details for current loans (if applicable), click "**Loan Details**" under the **Review** tab

NAME OR CHANGE A BENEFICIARY

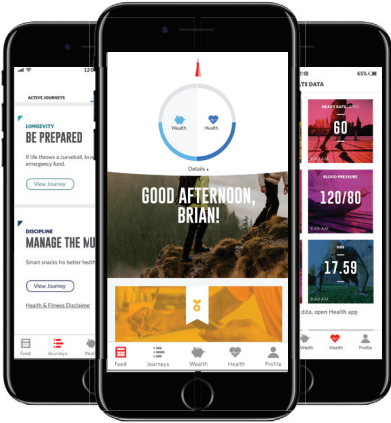
- To name or change your beneficiary, click "**Beneficiaries**" under the **Home** tab

Please note that if you are married and designate someone other than your spouse as a "primary" beneficiary, spousal consent may be required.

COMPLETE YOUR ONLINE PROFILE

- Add an email address to your account so you can be notified of suspicious account activity
- Create three security questions for additional account protection
- Consider adding an alternate email address for another line of communication

*See important disclosures on the following page.



DOWNLOAD THE TRANSAMERICA APP FROM THE APP STORE OR GOOGLE PLAY

With the Transamerica app, planning for your retirement has never been easier.

- View your account balance and rate of return
- Know *Your Retirement Outlook*[®]
- Take action right from your device



**PHONE ACCESS
800-401-8726**

Transamerica Voice Pass, our voice-recognition system, can provide security and convenience without having to remember a password when you call our Customer Care team. Voice Pass will identify you based on a stored voiceprint as unique as your fingerprint. Once set up, all you'll need to do when you call is repeat the phrase, "At Transamerica, my voice is my password" to access your account.

CALL US:

Step 1: Call 800-401-8726

Step 2: Let us know who you are. If you're calling from the phone number we have on file, we'll identify you that way. If you're calling from a different phone number, enter or say your Social Security number.

Step 3: If it's your first time calling, follow the prompts to set up Voice Pass. If you've called us before, we'll ask you to verify your identity using your voice.

Access Your Account Online to Get Started.

Tomorrow starts today.



Visit: transamerica.com/portal/home



Contact: 800-401-8726

IMPORTANT: The projections or other information generated by the engine, which produces *Your Retirement Outlook*[®], regarding the likelihood of various investment outcomes are hypothetical in nature, do not reflect actual investment results, and are not guarantees of future results. Results derived from the tool may vary with each use and over time. Please visit your plan website for more information regarding the criteria and methodology used, the engine's limitations and key assumptions, and other important information.

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TRANSAMERICA[®]

UIHV Offers two types of 401(k) plans in 2020 with Transamerica:

- 1. Traditional 401(k) - Pre-tax contributions**
- 2. Roth 401(k) - Post-tax contributions**

Eligibility

- At hire (must be at least 18 years old)
- Excludes PRN employees

Employer Matching Contributions

- 100% match on your contributions, up to 6% of pay at date of hire

Auto Enroll Employee Deferrals

- 6% at hire or eligibility or opt out
- Deferrals into the Voya Solution Portfolio

You Elect to Enroll

- 1-20% of your pay; you select from any of the 20+ investment funds
- Catch up contributions if 50 years old or more

Vesting

- 100% at hire on all contributions, match or rollovers
 - *Approved rollovers from other plans allowed

Changes to Contributions

- Can stop at any time
- First pay in any month (Change percentage of contribution, change Traditional to Roth)
 - **Changes to investments may be done at anytime by contacting Voya

Loans

- Minimum \$1,000 (fee of \$100 to process)
- Maximum is 50% vested balance or \$50,000
- Maximum of 5 separate loans at any time

Cafeteria/Flex Plan Enrollment Form

Company Name (Employer)

University of Iowa Community Medical Services

Employee Information

First Name	Last Name	Middle Initial
SSN	Date of Birth	Email <i>(required)</i>
Address	City	State/Zip

Enrollment Information

<input type="checkbox"/> New	<input checked="" type="checkbox"/> Renewal	Effective Date	01/01/2021	First Payroll Deduction Date	01/01/2021
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Unreimbursed Medical

Annual amount of Unreimbursed Medical \$	Annual employer contribution (if offered) \$	NA
Please check the one that applies to your situation	<input checked="" type="checkbox"/> Regular Flex Plan	<input type="checkbox"/> Limited Purpose Flex Plan (If you or your Spouse have an HSA.)

Maximum 2021 plan contribution: \$2750 over 26 pay periods.

Dependent Care

Annual election for dependent care \$	Annual employer contribution (if offered) \$	NA
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Maximum 2021 plan contribution: \$5000 over 26 pay periods.

Authorization: I certify the above information to be true to the best of my knowledge and that the children on whom I will be claiming dependent expenses or child care either reside with me in a parent child relationship or are legally dependent on me for their support. I agree to have my compensation reduced by the deduction amount(s) stated above. I understand that any amounts remaining in my account(s) not used for qualified expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the Flexible Compensation deduction(s) will be in effect for the entire plan year and cannot be revoked unless I experience a change in my family status or termination of employment.

Signature _____ Date _____

I decline to participate in the Flex Spending account

Signature _____ Date _____

Direct Deposit

If you are new to enrolling in the flex plan and are interested in signing up for direct deposit, please log in to the consumer portal <https://kabelparticipant.lh1ondemand.com> after the start of the new plan year. If you have already provided iSolved with direct deposit information in the past, there will be nothing further needed and we will continue to send your reimbursements as direct deposit. You can also update your banking information in the consumer portal.

2021 Medical Plan Selection Form

Due to the new dual plan offering, **all eligible employees are required to complete this 2021 Medical Plan Selection** form.

This form must be returned to Emily no later than **November, 23rd**.

Medical and Prescription Drug Plan		
Primary 1000 HMO		
	Monthly Employee Cost	Deduction Per Pay Period (26)
<input type="checkbox"/> Single	\$83.69	\$38.62
<input type="checkbox"/> Family	\$466.68	\$215.39
Primary 1000 POS		
	Monthly Employee Cost	Deduction Per Pay Period (26)
<input type="checkbox"/> Single	\$168.46	\$77.75
<input type="checkbox"/> Family	\$678.60	\$313.20
<input type="checkbox"/> <i>I wish to waive medical coverage.</i>		

Instructions: Please place an "X" in the box that coordinates with your election for 2021. Then sign and date at the bottom. Reminder, if you are making a change to who is enrolled on your plan you will also need to complete a Wellmark enrollment form.

Print Name

Sign

Date