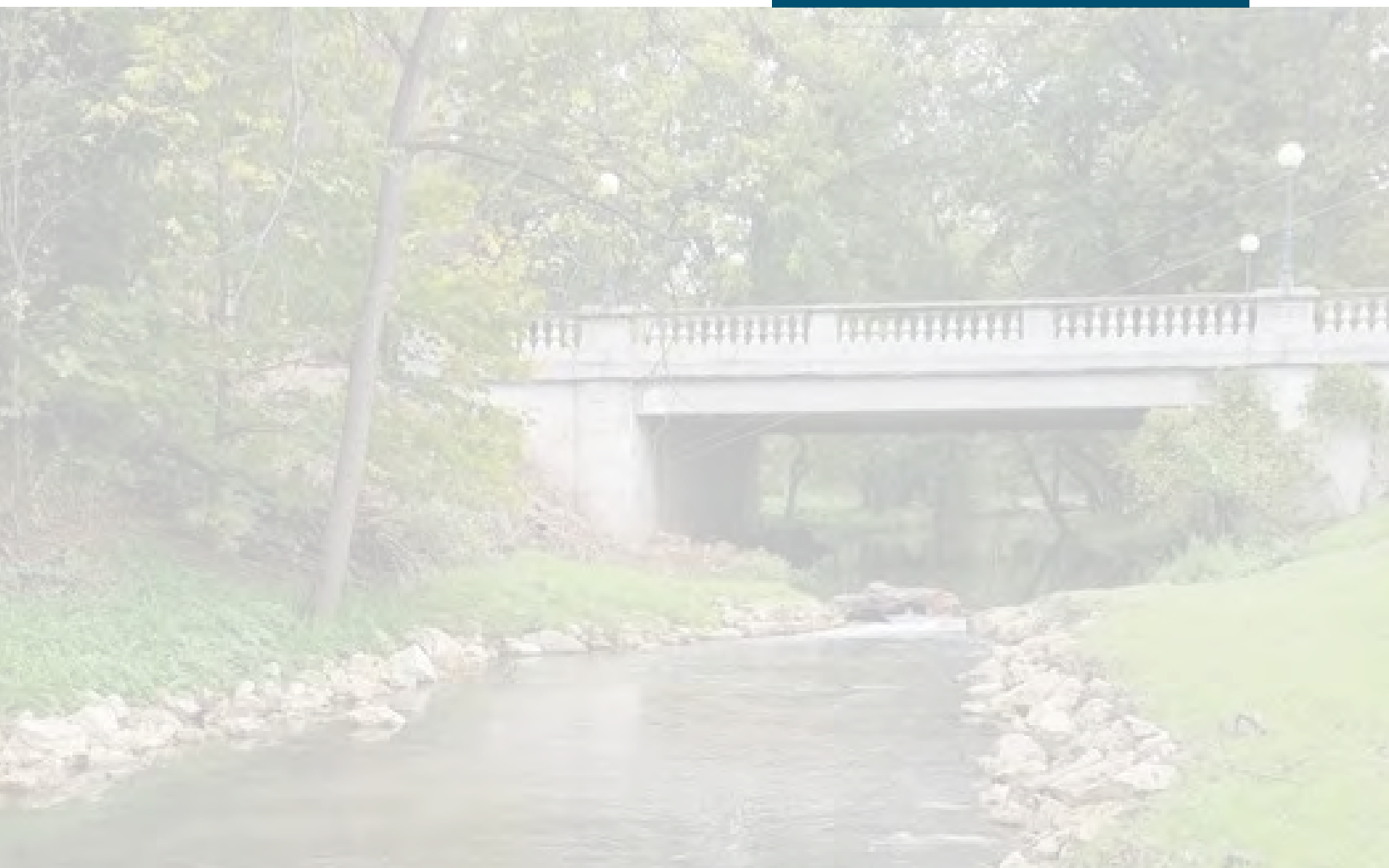
2025

BENEFITS ENROLLMENT GUIDE

THE Insurance CENTER



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

What Do I Need to Know?

Who Is Eligible?

Employees with Monroe County are eligible to enroll in the benefits outlined in this guide based on the hours specified in each plan.

How To Enroll?

Are you ready to enroll? The first step is to review your current benefits. Did you move recently or get married? Verify all of your personal information and make any necessary changes.

Once all your information is up to date, it's time to make your benefit elections. The decisions you make during open enrollment can have a significant impact on your life and finances, so it is important to weigh your options carefully.

When To Enroll?

The benefit choices you make now will cover you and your dependents through the entire year.

New employees are eligible for benefits the first of the month following 30 days of employment.

When To Make Changes?

Unless you experience a HIPAA Special Enrollment event, you cannot make changes to the benefits you elect until the next open enrollment period. A Special Enrollment event would include: A loss of eligibility for other health coverage, termination of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP), the acquisition of a new spouse or dependent by marriage, birth, adoption or placement for adoption, or becoming eligible for a premium assistance subsidy under Medicaid or a state CHIP.

In the case of a HIPAA Special Enrollment, you have 30 days to make changes to your benefit plans.

Please Note: The open enrollment of your spouse's health plan through their employer does not constitute a qualifying event for you unless there are significant changes to plan designs or rates. Please contact the Human Resources Department or The Insurance Center if you have questions.

Your Benefits

BENEFITS	CARRIER	WHO CONTRIBUTES	PREMIUM TAX TREATMENT
Employer Paid Life Insurance and AD&D	Standard Insurance Co.	Your Employer	N/A
Voluntary Life Insurance	Standard Insurance Co.	You	Post-tax
Dental Insurance	Delta Dental of WI	You & Your Employer	Pre-tax
Medical Insurance	Allegiance	You & Your Employer	Pre-tax
Direct Primary Care	Neighborhood Family Clinic	Your Employer	N/A
Thermography Services	Naturally Unbridled Wellness	Your Employer	N/A
Health Savings Account (HSA)	Bank of Choice	You	Pre-tax
Mental Health Support	Gundersen EAP	Your Employer	N/A
Flexible Spending Account (FSA)	Employee Benefits Corporation	You	Pre-tax
Accident Insurance	Allstate	You	Pre-Tax
Cancer Insurance	Allstate	You	Pre-Tax
Critical Illness Insurance	Allstate	You	Pre-tax

Did You Know?

Pre-tax vs. Post-tax Deductions

Pre-tax Deductions:

Costs of benefit elections are taken from your paycheck before any applicable taxes are deducted.

Post-tax Deductions:

Taken from your paycheck after any applicable taxes are deducted.

Employer Paid Term Life Insurance

The Standard

Monroe County provides employees with a $10,000 Employer Paid Term Life and Accidental Death & Dismemberment (AD&D) Insurance Plan.

The Benefit

Benefit Amount:
$10,000

Eligibility:
Actively working a minimum of 20 hours per week

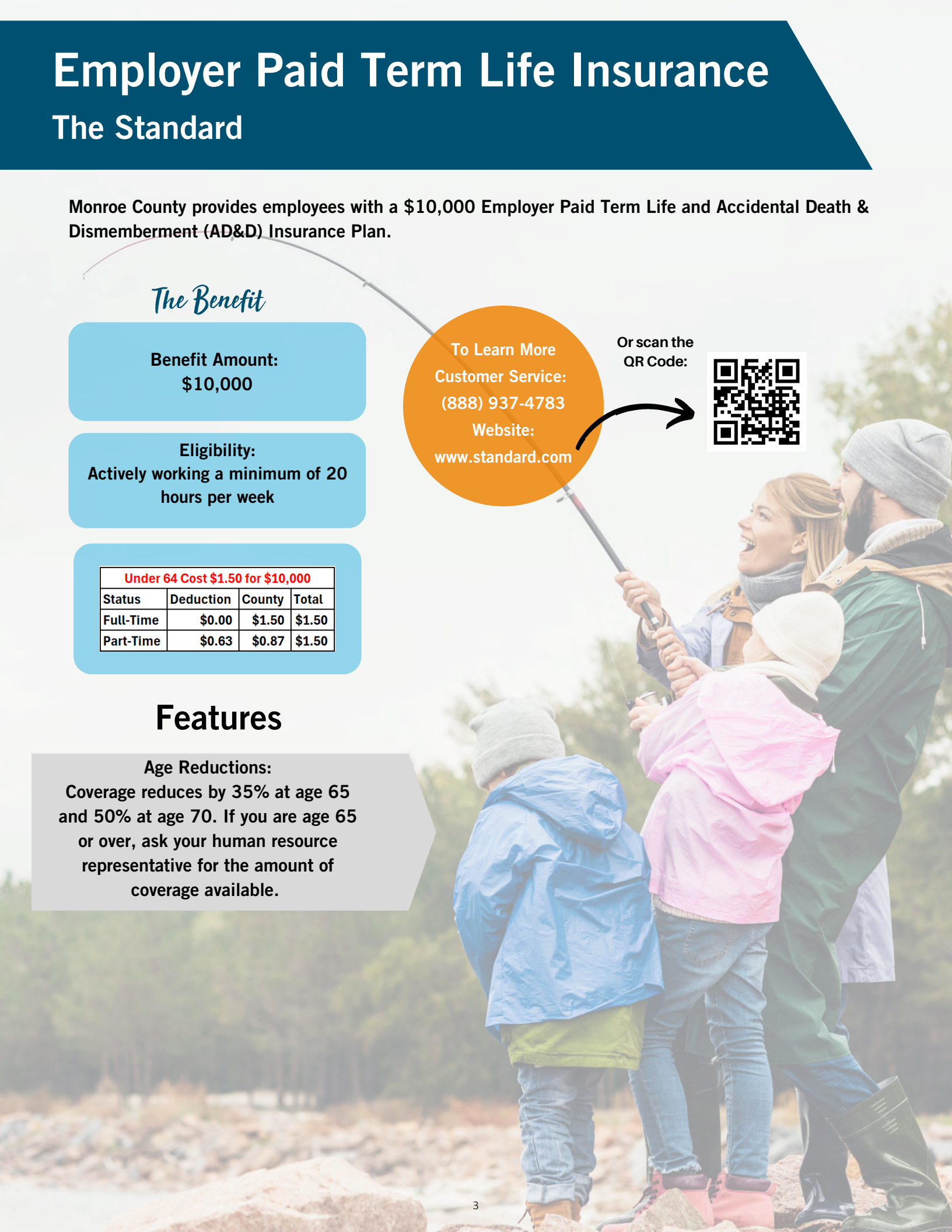
Under 64 Cost $1.50 for $10,000			
Status	Deduction	County	Total
Full-Time	$0.00	$1.50	$1.50
Part-Time	$0.63	$0.87	$1.50

To Learn More
Customer Service:
(888) 937-4783
Website:
www.standard.com

Or scan the QR Code:

Features

Age Reductions:
Coverage reduces by 35% at age 65 and 50% at age 70. If you are age 65 or over, ask your human resource representative for the amount of coverage available.



Voluntary Life Insurance

The Standard

Monroe County offers employees who work 20 hours or more per week the opportunity to enroll in Voluntary Life. The benefit is offered on a group basis which offers a lower premium for employees who are interested in purchasing additional Life Insurance.

The Benefit

Benefit Amount for You:
$10,000-$300,000
Not to exceed 5x's annual earnings

Employee Guarantee Issue: $100,000
See full rate chart below

*Benefit Amount for Your Spouse:
$5,000-$150,000
Maximum 50% of Employee's Amount

Spouse Guarantee Issue:
$25,000

*Benefit Amount for Your Child(ren):
$10,000

***Employee must elect coverage in order for spouse and dependents to elect.**

Features

Additional Benefits

- Waiver of Premium
- Portability

Age Reduction:
65-69 years old: 65%
70+ years old: 50%

Employee's Spouse Voluntary Life Premium Calculator
Cost Per Month

		Benefit	$5,000	$10,000	$15,000	$20,000	$25,000
Age	Rate per $1000						
<30	$0.085		$0.43	$0.85	$1.28	$1.70	$2.13
30-34	$0.100		$0.50	$1.00	$1.50	$2.00	$2.50
35-39	$0.110		$0.55	$1.10	$1.65	$2.20	$2.75
40-44	$0.190		$0.95	$1.90	$2.85	$3.80	$4.75
45-49	$0.355		$1.78	$3.55	$5.33	$7.10	$8.88
50-54	$0.590		$2.95	$5.90	$8.85	$11.80	$14.75
55-59	$1.060		$5.30	$10.60	$15.90	$21.20	$26.50
60-64	$1.680		$8.40	$16.80	$25.20	$33.60	$42.00
65+	$2.550		$12.75	$25.50	$38.25	$51.00	$63.75

*All rates are contingent upon the employee's age for spousal coverage

Employee Voluntary Life Premium Calculator
Cost Per Month

		Benefit	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000
Age	Rate per $1000											
<30	$0.085		$0.85	$1.70	$2.55	$3.40	$4.25	$5.10	$5.95	$6.80	$7.65	$8.50
30-34	$0.100		$1.00	$2.00	$3.00	$4.00	$5.00	$6.00	$7.00	$8.00	$9.00	$10.00
35-39	$0.110		$1.10	$2.20	$3.30	$4.40	$5.50	$6.60	$7.70	$8.80	$9.90	$11.00
40-44	$0.190		$1.90	$3.80	$5.70	$7.60	$9.50	$11.40	$13.30	$15.20	$17.10	$19.00
45-49	$0.355		$3.55	$7.10	$10.65	$14.20	$17.75	$21.30	$24.85	$28.40	$31.95	$35.50
50-54	$0.590		$5.90	$11.80	$17.70	$23.60	$29.50	$35.40	$41.30	$47.20	$53.10	$59.00
55-59	$1.060		$10.60	$21.20	$31.80	$42.40	$53.00	$63.60	$74.20	$84.80	$95.40	$106.00
60-64	$1.680		$16.80	$33.60	$50.40	$67.20	$84.00	$100.80	$117.60	$134.40	$151.20	$168.00
65+	$2.550		$25.50	$51.00	$76.50	$102.00	$127.50	$153.00	$178.50	$204.00	$229.50	$255.00

Rate for Your Child(ren) - Covered through age 20 (through age 24 if a registered student full-time attendance at an accredited educational institution)
$2.00/month per $10,000 of coverage
Note: Monthly rate covers all children

DENTAL INSURANCE

Delta Dental

Monroe County offers employees working 20 hours or more per week a Dental Insurance Plan through Delta Dental.

SERVICES	PPO PROVIDER	PREMIER NETWORK OR OTHER PROVIDER
ANNUAL DEDUCTIBLE	$50/Per Person	$50/Per Person
Individual Annual Maximum Per person, per calendar year	$1,000	$1,000
Preventative Services*	100% Covered by Delta Dental (Deductible does not apply)	100% Covered by Delta Dental (Deductible does not apply)
Basic Services	80% Covered after Deductible	80% Covered after Deductible
Major Services	50% Covered after Deductible	50% Covered after Deductible
Orthodontia	$1,500 Life Maximum Per child	$1,500 Life Maximum Per child

Preventative Services:	Cleanings (prophylaxis), fluoride treatments, sealants, evaluation, bitewing x-rays. ***Delta Dental will cover cleanings twice per plan year and charges will be applied to your Annual Maximum.**
Basic Services:	Emergency treatment to relieve pain, fillings and simple extractions.
Major Services:	Oral Surgery, crowns, bridges, dentures, implants, repairs and adjustments.

YOUR COST - MONTHLY DEDUCTIONS

Full-Time Employee:
$3.77 Single
$11.74 Family

Part-Time Employee:
$12.19 Single
$37.91 Family

FIND A DENTIST

Website: www.Deltadentalwi.com
Customer Service: 1-800-236-3712

Or scan the QR Code:

DELTA DENTAL

Finding a Network Dentist

A simple search tool to help make you smile.

At Delta Dental of Wisconsin, our dentist directories are accessible online, via our mobile app, and by phone.

Delta Dental has more than 145,000 participating dentists in our networks across the United States. More than three-fourths of U.S. dentists belong to a Delta Dental network.

on the web

- Go to **www.deltadentalwi.com** and select "Find A Network Dentist" from the "Provider Search" tab.
- Select a network* (Delta Dental PPO or Delta Dental Premier) from the dropdown menu.
- Enter your city and state, or ZIP code. The Advanced Options dropdown allows you to search for dentists by their last name or practice name. Dentist listings will appear according to distance.
- You can refine your search by specialty, gender, language spoken, and hours of operation as well as other criteria.
- Your search results can be sorted by distance, name, city, or zip code. This list can be printed, emailed, or saved as a PDF.

mobile app

Delta Dental's mobile app is available for smart phones and tablets using iOS (Apple) or Android. To download the app on your device, visit the App Store or Google Play and search for "Delta Dental."

- Log in to the mobile app and click on "Find a Dentist."
- Select a network* (Delta Dental PPO or Delta Dental Premier) from the dropdown menu.
- Search by address or current location.

Once you've found a dentist, save your dentist to your contacts, call to schedule a visit, or get directions to their office with the touch of your finger.

by phone

From a touch-tone phone, call **800-236-3712** and follow the automated instructions. Participating dentists are searched by ZIP code.

*Please visit the member connection at www.deltadentalwi.com to view plan design and network options available to you.

Connect With Us

www.deltadentalwi.com

SS302-1710

DELTA DENTAL®

Choosing a Network Dentist

Discover the advantages of going to a dentist who belongs to a Delta Dental network.

With two dentist networks available, which one is right for you? The Delta Dental PPO℠ network delivers the **greatest savings**, but fewer dentists belong. The Delta Dental Premier® network is the **largest dentist network**, but the savings aren't as significant as with a Delta Dental PPO provider. This illustration shows how **both networks save you money**. Seeing either a Delta Dental PPO dentist or Delta Dental Premier dentist will ensure that **treatments are guaranteed, claims are directly paid, and no balance-billing can occur.**

Example Savings for a Common Procedure

	Estimated Charge	Maximum Allowed Fees	Percentage Paid by Delta Dental	Amount Delta Dental Pays	Amount Dentist can Balance Bill	Total Amount You Pay	Your Total Cost Savings
PPO Network	$1,200	$825	80%	$660	$0	$165	$375
Premier Network	$1,200	$985	80%	$788	$0	$197	$215
Out-of-Network	$1,200	$925	80%	$740	$275	$460	$0

Delta Dental PPO network

Delta Dental PPO network **dentists have agreed to charge $825 for the $1,200 service, a savings of $375.** Your **Delta Dental plan covers 80 percent** of the cost. Assuming you've already met your deductible for the year, **Delta Dental will pay $660** and **you'll pay $165.**

Delta Dental Premier network

Delta Dental Premier network dentists have **agreed to charge $985 – a savings of $215** compared to the fee the dentist charges non-network patients. Assuming you've met your deductible, **Delta Dental will cover 80 percent** of that $985, **paying $788. You'll pay $197.** That's an extra **$32 tacked on to your share of the bill** when compared to what you would have paid with a Delta Dental PPO dentist.

Out-of-network

Out-of-network dentists **have not agreed to charge a lower fee and can bill the full $1,200.** Delta Dental has set a limit on the accepted amount at $925, which means **Delta Dental's share of the tab is $740.** The dentist can bill you the difference between the maximum allowed fee and what they charge. This leaves **you with a bill of $460, which includes the $275 the out-of-network dentist can "balance bill."**

www.deltadentalwi.com

SS319-1810

Health Insurance

Smart Healthcare Consumer Plan

Monroe County offers full time employees two comprehensive health plan options to choose from. The plan outlined below is the Smart Healthcare Consumer Plan. This plan allows members three tiers of in-network providers to choose from based on overall price, quality and value they provide. Members may choose to use providers amongst all or any of these tiers, however, choosing the lower Tier's allows for less out of pocket cost.

NETWORK	Tier 1 High Value Providers **NO COST**	Tier 2 Alliance Premier Network **Copays Only**	Tier 3 Remaining Alliance Network **Subject to Deductible**	Tier 4 **Out-of-Network** **Not Covered**
Deductible	$0 Individual $0 Family	$0 Individual $0 Family	$8,000 Individual $16,000 Family	NO BENEFIT
Maximum Out-of-Pocket (Medical and Rx Combined)	$0 Individual $0 Family	$4,000 Individual $8,000 Family	$8,000 Individual $16,000 Family	NO BENEFIT
Maximum Out of Pocket accumulations are separate and do not cross accumulate. However, the Out-of-Pocket Maximum between Tier 2 and Tier 3 shall not exceed $9,200 per Covered Person or $18,400 per Family per Benefit Period.				
Preventative Care Includes Well Adult, Well Child Visits and Child Routine Eye Exams	100% Covered	100% Covered	100% Covered	NO BENEFIT
Office Visit	100% Covered	$75 Copay	100% After Deductible	NO BENEFIT
Specialist Visit	100% Covered	$150 Copay	100% After Deductible	NO BENEFIT
Chiropractic	100% Covered	$25 Copay	100% After Deductible	NO BENEFIT
Imaging CT, PET Scans, MRI	100% Covered	$500 Copay	100% After Deductible	NO BENEFIT
Diagnostic Tests X-Ray, Labs	100% Covered	$100 Copay	100% After Deductible	NO BENEFIT
Inpatient Hospital	100% Covered	$500 Copay	100% After Deductible	NO BENEFIT
Urgent Care	100% Covered	$150 Copay	100% After Deductible	NO BENEFIT
Emergency Facility & Professional Services Emergency Only	$500 Copay, then covered 100%, deductible waived Additional services, such as lab, x-rays, etc. will have additional costs			
Ambulance Service Air or Ground	$500 Copay, then covered 100%, deductible waived			
Adult Eye Exam	100% Covered	$50 Copay	100% After Deductible	NO BENEFIT
Mental Health/Behavioral Health/Substance Abuse				
Office Visit	100% Covered	$50 Copay	100% After Deductible	NO BENEFIT
Outpatient Services	100% Covered	$150 Copay	100% After Deductible	NO BENEFIT
Inpatient Services	100% Covered	$500 Copay	100% After Deductible	NO BENEFIT

Benefit limit: 20 treatments per benefit period for Chiropractic and Acupuncture Treatment. "Treatment" includes all services provided including x-rays

Health Insurance

Smart Healthcare Consumer Plan

NETWORK	Tier 1 High Value Providers **NO COST**	Tier 2 Alliance Premier Network **Copays Only**	Tier 3 Remaining Alliance Network **Subject to Deductible**	Tier 4 **Out-of-Network Not Covered**
Deductible	$0 Individual $0 Family	$0 Individual $0 Family	$8,000 Individual $16,000 Family	NO BENEFIT
Maximum Out-of-Pocket (Medical and Rx Combined)	$0 Individual $0 Family	$4,000 Individual $8,000 Family	$8,000 Individual $16,000 Family	NO BENEFIT
Maximum Out of Pocket accumulations are separate and do not cross accumulate. However, the Out-of-Pocket Maximum between Tier 2 and Tier 3 shall not exceed $9,200 per Covered Person or $18,400 per Family per Benefit Period.				
Colonoscopy-Diagnostic Preventative Covered at 100%	100% Covered	$500 Copay	100% After Deductible	NO BENEFIT
Mammogram- Diagnostic **Preventative** Covered at 100%	100% Covered	$100 Copay	100% After Deductible	NO BENEFIT
Occupational/Speech/ Physical Therapy	100% Covered	$50 Copay	100% After Deductible	NO BENEFIT
Sports Physicals	100% Covered	$75 PCP/$150 SCP	100% After Deductible	NO BENEFIT
Telemedicine (Other than Recuro)	100% Covered	$75 PCP/$150 SCP	100% After Deductible	NO BENEFIT
Durable Medical Equipment Rental	100% Covered	$50 Copay	100% After Deductible	NO BENEFIT
Durable Medical Equipment Purchase	100% Covered	$500 Copay	100% After Deductible	NO BENEFIT
• **Prosthetic Appliances** • **Orthopedic Devices** • **Other Medical Supplies**	100% Covered	$150 Copay	100% After Deductible	NO BENEFIT
Prescription Drug Benefit				
Tier 1	Lesser of cost or $10 (1- 30 Day Supply) Lesser of cost or $20 (31-60 Day Supply) Lesser of cost or $30 (61-90 Day Supply)			
Tier 2	Lesser of cost or $50 (1- 30 Day Supply) Lesser of cost or $100 (31-60 Day Supply) Lesser of cost or $150 (61-90 Day Supply)			
Tier 3	Lesser of cost or $100 (1- 30 Day Supply) Lesser of cost or $200 (31-60 Day Supply) Lesser of cost or $300 (61-90 Day Supply)			
Specialty	25% Copayment (30 Day Supply)			

Please see Summary of Benefits Coverage (SBC) and/or Summary Plan Description (SPD) for full summary of all coverages.
This plan is embedded. With an embedded deductible/OPM, the plan begins to pay as soon as one member of the family has reached their individual deductible. One member in the family would never pay more than the individual deductible and out of pocket maximum amounts. The remaining members in the family would then work together to collectively meet the family deductible and out of pocket maximum.
PCP: Primary Care Physician. SP: Specialty Care Physician

Health Insurance

HSA Health Plan

Monroe County offers employees two comprehensive health plan options to choose from. The plan outlined below is the HSA Health Plan. Enrolling in this health plan allows for eligibility to contribute to a Health Savings Account (HSA) with pre-tax earnings. See Page 26 for additional information regarding Health Savings Accounts.

Coverage	HSA Plan In-Network
Deductible	$3,500 Individual $7,000 Family
Coinsurance	90% Employer / 10% Employee
Maximum Out-of-Pocket (Medical and Rx Combined)	$7,000 Individual $14,000 Family
Preventative Care (Includes Well Adult, Well Child Visits and Annual Eye Exam)	Covered 100%
OFFICE VISITS	Price Charged goes towards Deductible, then covered at 90%
SPECIALIST VISIT	Price Charged goes towards Deductible, then covered at 90%
URGENT CARE	Price Charged goes towards Deductible, then covered at 90%
EMERGENCY ROOM	Price Charged goes towards Deductible, then covered at 90%
PRESCRIPTION BENEFIT	Price Charged goes towards Deductible, then covered at 90% ***Includes $0 Preventative Drug List***

This plan is embedded. With an embedded deductible/OPM, the plan begins to pay as soon as one member of the family has reached their individual deductible. One member in the family would never pay more than the individual deductible and out of pocket maximum amounts. The remaining members in the family would then work together to collectively meet the family deductible and out of pocket maximum.

2025 Health Plan Costs

Full-Time Employees: Single	SMART PLAN	HSA PLAN
Total Bi-Weekly Premium before Employer Contribution:	$580.00	$650.00
Bi-Weekly Employer Contribution:	$493.00	$552.50
Employee Bi-Weekly Payroll Deduction:	**$87.00**	**$97.50**

Full-Time Employees: Family	SMART PLAN	HSA PLAN
Total Bi-Weekly Premium before Employer Contribution:	$1,320.00	$1,500.00
Bi-Weekly Employer Contribution:	$1,122.00	$1,275.00
Employee Bi-Weekly Payroll Deduction:	**$198.00**	**$225.00**

Part-Time Employees: Single	SMART PLAN	HSA PLAN
Total Bi-Weekly Premium before Employer Contribution:	$580.00	$650.00
Bi-Weekly Employer Contribution:	$336.40	$377.00
Employee Bi-Weekly Payroll Deduction:	**$243.60**	**$273.00**

Part-Time Employees: Family	SMART PLAN	HSA PLAN
Total Bi-Weekly Premium before Employer Contribution:	$1,320.00	$1,500.00
Bi-Weekly Employer Contribution:	$765.60	$870.00
Employee Bi-Weekly Payroll Deduction:	**$554.40**	**$630.00**

Those who elect not to participate in the voluntary Health Promotion Program (HPP) while enrolled in the health plan will pay a non-participation surcharge of $20 single / $45 family per deduction.

HealthCARE At No Cost To You

Costs covered on behalf of your Employer

All Services Covered at NO COST to all Employees & their Dependents

NEIGHBORHOOD - Family Clinics - Affordable ~ Accessible

www.mynfclinics.com

La Crosse	Onalaska	West Salem	Sparta	Viroqua
1526 Rose Street La Crosse, WI 54603 608-781-9880	N5560 CTH ZM Onalaska, WI 54650 608-779-5323	1580 Heritage Blvd West Salem, WI 54669 608-518-3410	128 S Water, Suite B Sparta, WI 54656 608-351-2820	1316 Bad Axe Court Viroqua, WI 54665 608-518-3745
Mon-Fri: 7am - 6pm Sat: 7am - 1pm	Monday-Friday: 8am - 4pm	Monday-Friday: 8am - 1pm	Monday: 8am - 4pm Tues & Thurs: 8am - 6pm Wed & Fri: 8am-2pm	Mon & Tues: 8am - 4pm Wed & Thurs: 8am - 3pm Fri: 8am-1pm

Service

- Office Visit
- Extended/Specialty Office Visit
- School, Camp, Sports Physicals
- DOT Exam/Follow Up Exam
- Health Coaching & Nutritional Counseling
- Women's Health/Pap

Procedures

- Laceration Repairs
- Ear Wax Removal (impacted)
- Incision & Drainage
- Nebulizer Treatment
- X-Rays with Interpretation
- EKG with Interpretation
- Endometrial Biopsy
- Mole/Tissue Biopsy
- Liquid Nitrogen
- Wound Surface Culture Technique
- Injection of Joints/Cortisone/Multiple
- Foot Care

Additional Testing

- Audiometer
- Spirometry
- Tympanogram
- FIT (Colorectal Screening)

Injections

- Toradol Injections
- Epinephrine
- Vitamin B12/Testosterone
- Dep Medrol-Methylprednisolone

Immunizations

- Varivax (Chickenpox)
- Meningitis
- Hepatitis
- Tdap (11+)
- DTap (6 wks- 6)
- Tetanus (7+)
- TB Test-PPD
- Flu Shot
- Shingrix
- MMR
- Prevnar 20
- Polio

Miscellaneous

- Oral Antibiotics 3-10 days
- Liquid Antibiotics/Eye Drops/Triamcinolone
- Casting
- Splinting
- Orthotics
- Supplies

Lab Work

- Cortisol
- D-Dimer
- Estradiol
- Estrogen
- Progesterone
- Testosterone M/F
- Folic Acid

Lab Work Continued.....

- Lyme Test
- C-Reactive Protein-CRP
- Protime/INR
- Hemoglobin A1C
- Glucose/Sugar
- Urinalysis
- Rapid Strep Test
- Pregnancy Urine Lab
- Lipid Panel Cholesterol
- Thyroid/TSH/T3/T4
- Prostate-PSA
- Pap Smear/HPV
- Complete Blood Count/CBC
- Chlamydia/Gonorrhea
- HIV
- VDRL
- Amylase
- ANA Screen
- B-12 Levels
- Iron
- Metabolic Panel
- Hep A/B/C
- Mono
- Rapid Strep Throat
- RSV
- Vitamin D
- FSH
- H.Pylori Antibody
- Ova/Parasite

This does not encompass all Venipuncture

If you visit any Neighborhood Family Clinic location, medical services will be covered at 100% by your Employer.

The list of services noted above is not all encompassing. For a full list of services, please contact The Neighborhood Family Clinic or visit their website, www.mynfclinics.com. Please Note: does not offer Chiropractic, Physical Therapy or Massage Therapy.

THERMOGRAPHY BENEFIT

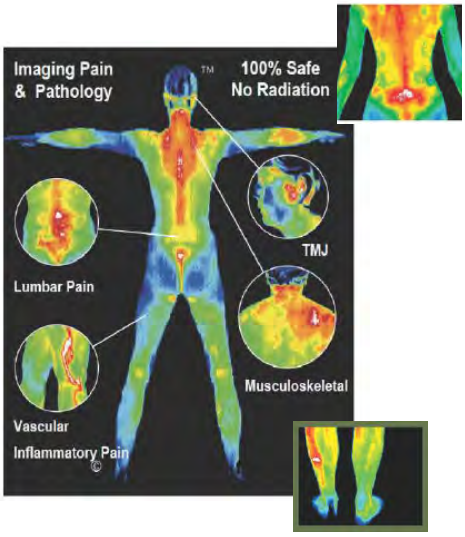
Your employer, under the self-insured health plan, is offering this service at no cost to you and/or covered family members!

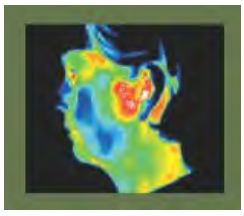
WHAT IS THERMOGRAPHY?

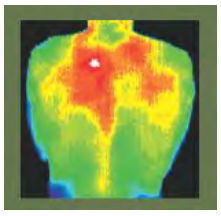
Thermography is a non-invasive, clinical imaging procedure that is used in the detection and monitoring of a number of diseases and physical injuries, often unseen by other testing, by showing thermal abnormalities present in the body through Digital Infrared Thermal Imaging (DITI)

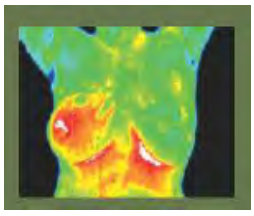
It can be used to aid for diagnosis and prognosis, as well as monitoring therapy progress for conditions and injuries, including:

- Inflammation
- Back Injuries
- Arthritis
- Headache
- Nerve Damage
- Unexplained Pain
- Dental and TMJ
- Vascular Disease
- Breast Imaging
- Inflammatory Pain
- Referred Pain Syndromes
- Sprain/Strain
- Digestive Disorders









HOW DO I GET STARTED?

Make an appointment by calling Naturally Unbridled Wellness directly. Referral is not required.

(be sure to let them know who your employer is and that the Thermography is billed directly to your employer).

Scan the QR Code to visit the Naturally Unbridled Wellness website

WHY THERMOGRAPHY AT NATURALLY UNBRIDLED WELLNESS?

- ✓ Non-Invasive
- ✓ Radiation Free
- ✓ Painless
- ✓ No contact with the body
- ✓ FDA regulated as an adjunctive diagnostic test

Naturally Unbridled Wellness
608-799-8326
1285 Rudy Street, Suite 104
Onalaska, WI 54650
Monday-Thursday 9AM-6PM
Friday 9AM-4PM

Alithias Care Advocacy

alithias
Power over healthcare's price.

Have Healthcare Benefit Plan Questions?

Alithias is here to help. Your Care Advocate can guide you through your benefit plan by:

- Answering benefit questions
- Researching and assist with billing issues
- Explaining your Explanation Of Benefits (EOB) along with the bill from your provider
- Helping you find an in-network provider
- Connecting you with other benefit programs

855- 270- 2850

Cost Estimate For HealthCare

alithias
Power over healthcare's price.

How To Research Healthcare Cost &Quality

...And Possibly Get A Cash Incentive!

Step 1

Call an Alithias Care Advocate for:

- Finding high quality, in-network Doctors
- Navigation for obtaining additional medical services

Step 2

Ask your provider to send a copy of the order to Alithias.

1. Fax the order or referral to: (855) 860-3123
2. Email the order or referral to

askme@careadvocacycenter.com

Step 3

You MUST call Alithias at (855)270-2850 to discuss personal preferences prior to obtaining your Care Navigation Report

Research can take 1-3 business days.

Step 4

Your Care Navigation Report will be sent to you via email.

- Review the options.
- Schedule your appointment
- Notify your Advocate about which provider you chose

Step 5

Complete the survey you receive via email to be eligible for possible cash incentives.

You will receive the incentive in a future paycheck; contact your HR Department for more details.

You can email us here:

askme@careadvocacycenter.com

Incentives for Being A Good HealthCARE Consumer!

2025 Alithias Procedure Incentive Offerings

Applies to ONLY those who are enrolled in the HSA Plan

Your Employer will offer the incentive listed in the orange column if you and/or your dependents on the health plan are using your Care Navigator **Alithias *proactively*** to find the most Fair Priced, High Value provider for the below listed procedures. This offers a significant savings to YOU, the consumer of HealthCARE!

Mayo Complex Care Program for Complex Diagnosis Procedures:

Medical Review and Second Opinion for Cancer, Neck, Back & Spine, Transplants, etc. → **100% Covered**

Procedures		Incentive Amount Paid to Member when using Alithias Proactively ↓	Midwest Estimated Cost Range Between Health Care Facilities	
			Low Cost	High Cost
Infusions: • Smart Infusion • OSMS Green Bay • GI Associates and other Centers of Excellence		**$750**	$6,500	>$13,000
Women's Health	Breast Biopsy	**$250**	$1,500	$8,500
	Hysterectomy	**$1,000**	$11,500	$34,855
Gastro-Intestinal				
	Colonoscopy (Screening and/or Polyp Removal)	**$350**	$2,000	>$20,000
	Cologuard Screening	**$500**	$1,500	>$10,000
	Upper GI (endoscopy with or w/o biopsy)	**$350**		
Diagnostic Imaging/Radiology				
Services administered within our High-Value Locations; Sensible MRI, SMT, Smart Scan, MH Imaging	CT Scans	**$350**	$600	$4,600
	MRI	**$600**	$450	$5,400
	Ultrasound	**$50**	$250	$800
	X-Ray	**$50**	$70	$250
Ear, Nose and Throat				
	Nasal/Sinus Septoplasty	**$500**	$4,400	$17,381
	Sleep Study (at home)	**$250**	$250	$800
	Sleep Study (in clinic)	**$250**	$1,400	$4,100
	Tonsilectomy/Adenoids	**$500**	$4,200	$9,850
	Tympanostomy/Myringotomy (Ear Tubes)	**$500**	$2,850	$12,891

**This is not an all-inclusive list of incentive offerings. If the high value option(s) being offered provides a nominal savings opportunity, additional incentives may be offered. Approval of such, required by employer.

2025 Alithias Incentive Offerings

Applies to ONLY those who are enrolled in the HSA Plan

Procedures	Incentive Amount Paid to Member when using Alithias Proactively ↓	Midwest Estimated Cost Range Between Health Care Facilities	
		Low Cost	High Cost
Allergy/Asthma			
Allergy/Asthma Complete Workup	**$150**	$1,900	$4,550
Cardiology			
ECG, ECG with tracing and report	**$300**	$900	$3,500
Doppler ECG	**$300**	$900	$3,800
Cardiovascular Stress Test	**$250**	$950	$2,680
General Surgery			
Gallbladder Removal	**$1,000**	$9,500	$24,972
Groin-Hernia Repair>5 years and older	**$1,000**	$3,900	$19,827
Orthopedics			
Hand Surgery (Carpal Tunnel)	**$500**	$3,500	$12,300
Knee Shaving and Debridement (Arthroscopy)	**$500**	$6,250	$18,430
Knee Meniscus/Cartilage Repair	**$500**	$6,500	$18,430
Knee Ligament Repair	**$1,000**	$12,500	$29,000
Shoulder Rotator Cuff	**$1,000**	$16,500	$39,309
Total Hip Replacement	**$3,000**	$27,500	>$80,000
Total Knee Replacement	**$3,000**	$27,500	>$80,000
Spine/Level 1 or 2 Cervical Fusion or Disc Arthroplasty	**$3,000**	$26,500	>$80,000
Second Opinion for Shoulder/Hip/Knee/Spine done with a Center of Excellence	**$500**		
Spine Lumbar Fusion	**$3,000**	$26,500	>$80,000
Urology			
Kidney Stones-Lithotripsy	**$1,000**	$9,950	$24,375
Vasectomy	**$250**	$1,600	$10,000

**This is not an all-inclusive list of incentive offerings. If the high value option(s) being offered provides a nominal savings opportunity, additional incentives may be offered. Approval of such, required by employer.

Virtual Urgent Care

Getting Started

INTRODUCTION

Access board-certified physicians 24/7, 365 days a year for urgent medical needs. Doctors will discuss your symptoms, confirm a diagnosis, and prescribe any needed medication. Video and telephone-based visits are available, with an average wait time of just ten minutes.

Cost Per Visit

$40 HSA Plan

$0 Smart Consumer Plan

HOW TO ACCESS

1. **Sign up with the Recuro Care app or visit: member.recurohealth.com**
2. **Enter your Allegiance member ID**
3. **Create your username and password**
4. **Complete your medical history**
5. **Schedule your consult**

***Registering your account is not required to use the service, you can call 855.6RECURO anytime for 24/7 access to doctors.**

Example Conditions Treated

- Acne / Rash
- Allergies
- Cold / Flu
- GI Issues
- Ear Problems
- Fever
- Insect Bites
- Nausea
- Pink Eye
- Respiratory
- UTI's
- And More...

Recuro Care
Digital Health Solutions
Open

RECURO HEALTH

customerservice@recurohealth.com| 855.6RECURO| Scan QR Code to Download

Roadmap to Mental Health Support

Wire HEALTH

Patient Care Coordination is Multi-Directional

Working together to surround the family with the best care of each person

Call
Care Navigators
855-270-2850

Text
Wire Health
414-626-0120

Scan
our QR Code

https://wire.health

Online Features for Members

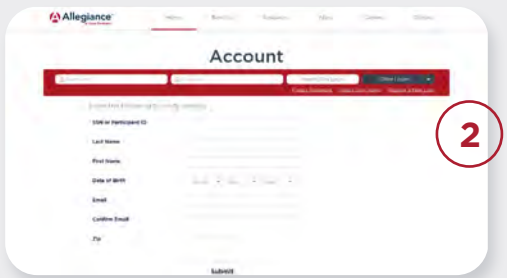
You can use your custom site for instant access to claims' status, eligibility, benefits information, ID cards and more. This guide will provide an overview on navigating the updated site and using its services. To get started, create a login at: **www. askallegiance.com**

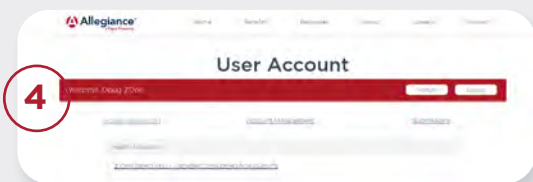
Logging In

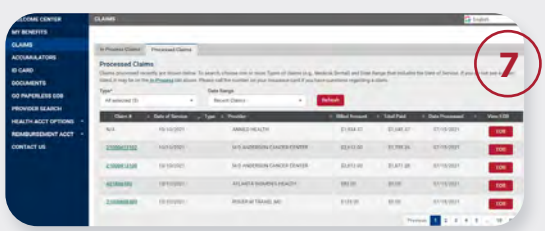
1. To set up new login information, click on **Health/Reimbursement Login**, then **Register New User** at the bottom of the box. You will be required to enter basic demographic information to verify your identity.
2. Once you enter this information, the system will ask you to create a username and password. Please note the specific character and length requirements.
3. After clicking **Submit**, the system will return you to the main login page. Enter your newly created username and password to continue on to the online member portal.
4. The Allegiance online portal allows you to access multiple Allegiance services through a single login. After entering your username and password information, please select the service you are looking for. Note that depending on which services you have elected, some members may see one or multiple options.

Online Services

5. The **WELCOME CENTER** includes an overview of your key Health Plan information. Review eligibility, recent claims and more all from this home page.
6. **MY BENEFITS** shows demographic information for you and any enrolled dependents as well as all active plan information.
7. The **CLAIMS** page has views for all processed claims as well as a tab for in-process claims. The **Type** and **Date Range** boxes allow you to filter claims.





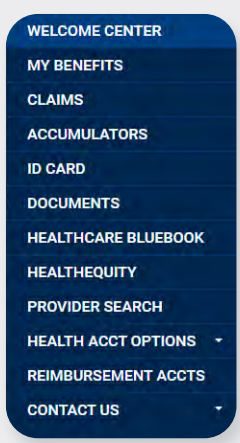


Online Services

8. Select the **Claim #** to pull up a detailed view of a specific claim or click the **EOB** button to load your Explanation of Benefits.
9. On the **ACCUMULATORS** page, you can review your current accumulator status including Single and Family deductibles and out-of-pocket maximums.
10. Under **ID CARD**, clicking the **Get ID Card Now** button will instantly load an electronic version of your ID Card.
11. If you need a replacement hard copy ID Card, select **Request ID Card by Mail**. Complete the short form and confirm the address for your card; Allegiance will verify your information and a new card will be mailed to you.
12. For your SPD, SBC, and other important materials, go to the **DOCUMENTS** page.
13. Looking to reduce the papers lying around? Select the **GO PAPERLESS EOB** page and elect to review Explanation of Benefits electronically. After confirming your email, you will receive a notice every time a new EOB is posted, so you can easily and quickly access it online without needing to wait for a hard copy in the mail.
14. Depending on your Health Plan, you may see additional options such as **HEALTHCARE BLUEBOOK, PROVIDER SEARCH**, and others. These links will connect you to other online services through a single sign-on.

The **www. askallegiance.com** portal provides all of the information you need to manage your Health Plan, but if you ever have questions around the portal or any of your benefits, please call your dedicated Member Advocates at the services number on your Health Plan ID Card.

14

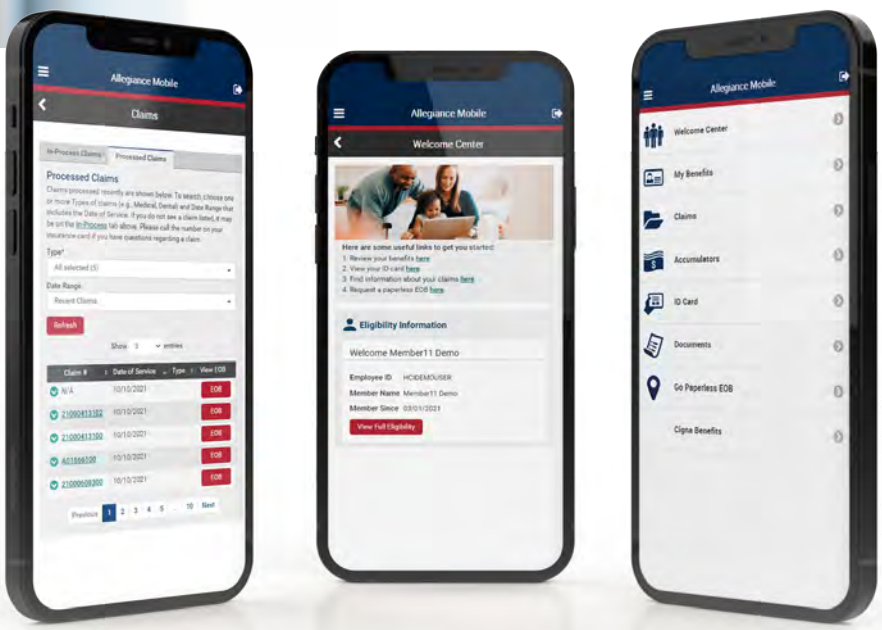


Allegiance®
a Cigna Company

ALLEGIANCE Mobile App

HEALTH

Access your health plan 24/7 with the Allegiance Mobile App! Simply download the app and login with your participant ID. New users should first create a login at www.AskAllegiance.com.



The app makes it easy and convenient to:

- View claims and EOBs
- Verify benefits and eligibility
- Access an electronic version of your ID Card
- Search for a provider

Available on the App Store

ANDROID APP ON Google Play

Start managing your account in seconds straight from your device!

Download the Allegiance Mobile App for free from the Apple App Store or Google Play today.

Mayo Clinic Complex Care Program

Available to those who are enrolled in the HSA Plan

Mayo Clinic Complex Care Program

MAYO CLINIC

If you are facing complex health challenges, you may be eligible for care at Mayo Clinic with travel and lodging paid for by your employer.

The Mayo Clinic Complex Care Program is an enhanced health care benefit for:

- Cancer
- Spine health
- Transplant (solid organ and bone marrow transplant)
- Undiagnosed/diagnostic odyssey – conditions for which you've been unable to find answers from other medical providers

STEP 1. Get started

Call Alithias Care Navigators at 855-270-2850 for full details, help with collecting your medical records and to get connected with Mayo Clinic.

STEP 2. Medical review

A Mayo Clinic specialist will review your medical records and determine if you would benefit from care at Mayo Clinic.

STEP 3. Travel to Mayo Clinic for care

Mayo Clinic will call you to coordinate your travel, lodging and appointment itinerary for you and a caregiver.

STEP 4. Return home

After you return home, your local medical provider and Mayo Clinic will work closely to coordinate your ongoing care.

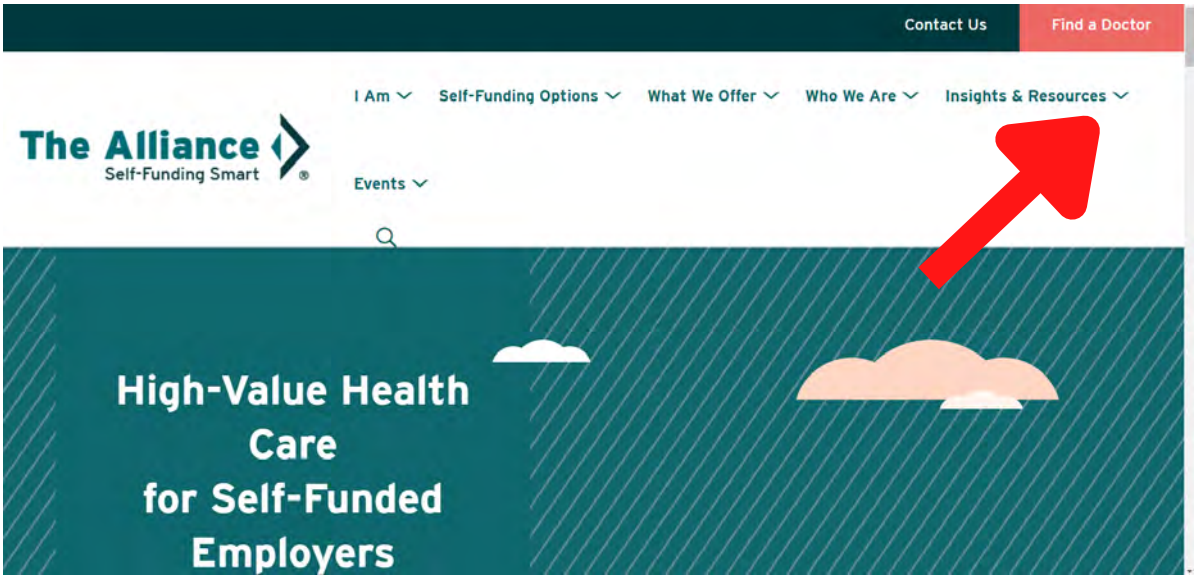
MC4432-48

How To Find A Provider

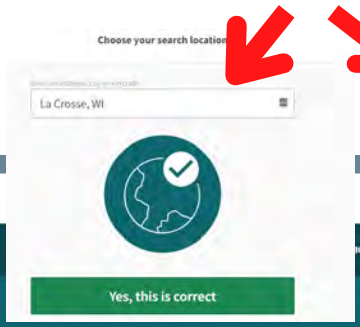
(within WI & select MN Counties)

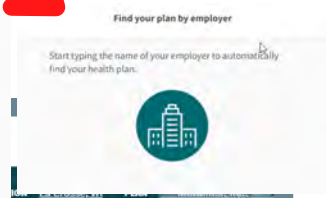
The Alliance/Trilogy Network:

www.the-alliance.org



It will then prompt you to input the city in which you are searching and the name of your Employer Group





Prescription Savings Tips

DID YOU KNOW?

Did you know that taking advantage of Mail Order can often save you money! Mail Order can generally offer a 90 day supply at the same cost as a 60 day supply. Not to mention the convenience of having it delivered directly to your house versus stopping at the retail pharmacy location every month.

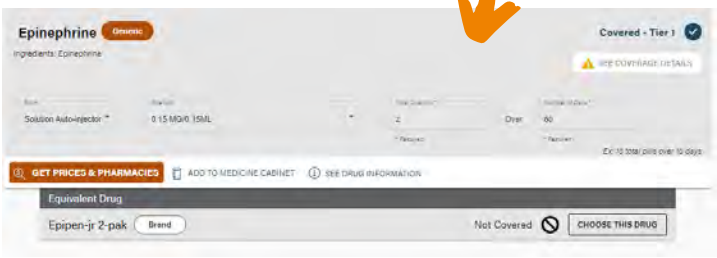
Cost and Mail Order can vary depending on your specific Pharmacy contract

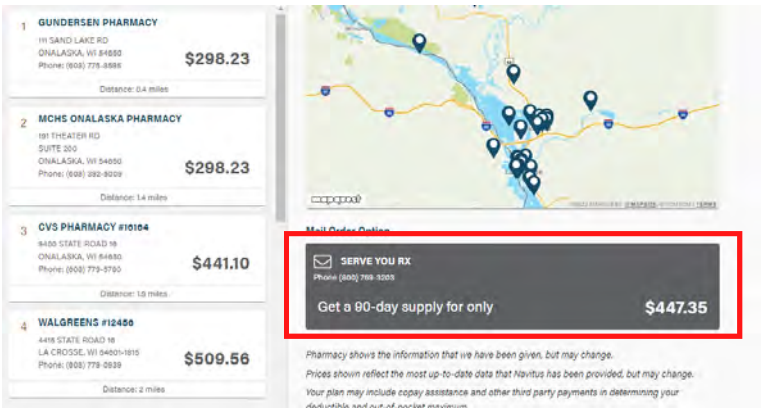
NAVITUS
PHARMACY BENEFITS REINVENTED™

Visit the Navitus member portal to:

- Check prices at local pharmacies vs. mail order
- Estimate your copay in real time
- Search based on your prescription history

Example of using the Cost Compare tool on the Navitus portal for an Epipen Prescription (Generic EPINEPHRINE) 4 pack as a 60 day Retail cost versus a 90 day Mail Order cost:





Always check the Mail Order option as some prescriptions may offer additional savings with a 90 day supply versus a 60 day supply!

To set up your portal access scan the QR Code:

1. Select PORTAL LOGIN < MEMBER PORTAL
2. When creating your account, you will use your Participant ID# from your medical card as your Member ID, followed by a 2-digit Person Code.
3. As the employee, your Person Code is 00, Spouse is 01, Dependents are 03, 04, etc. This number needs to be added to the end of your Member ID# to verify your active coverage and establish your account.

Example: 774381 is my Participant ID# from my medical card. I would enter 77438100 as my Member ID# on the Navitus portal.

Health Savings Account (HSA)

Only applicable if enrolling in the HSA Health Plan

A Health Savings Account (HSA) is an employee-owned account meant to pay for healthcare expenses. To maximize tax benefits, HSA funds must be used for qualified medical, dental, vision and pharmaceutical expenses.

Annual Contributions Limits

Individual Maximum:
2024: $4,150
2025: $4,300

Family Maximum:
2024: $8,300
2025: $8,550

Catch Up Contribution:
An additional $1,000 annual contribution can be made for members 55 and older.

Bank:
You will need to open an HSA Account at any bank of your choice. You will then need to provide the account and routing number to HR for your payroll deductions to be set up

How much can I save by using an HSA? This example shows an individual earning $40,000 per year, with an additional $600 of take home income by using an HSA vs. paying for medical expenses out of pocket with after tax money.

	Without HSA	With HSA
You Earn:	$3,333 per month	$3,333 per month
You Set Aside (Pre-Tax):	$0 per month	$200 per month
IRS Taxes You on:	$3,333 per month	$3,133 per month
Dollars spent on medical, dental & vision expenses for your family	$2,400 per year	$2,400 per year
You Take Home:	$27,600 per year	$28,200 per year

Your personal income and tax savings may vary based on income, tax rate, and the amount you contribute to your HSA account.

Why an HSA?

- You can make pre-tax deposits to the account through payroll deductions.
- An HSA account reduces your taxable income by up to 28%.
- These accounts operate just like a checking account with a debit card.
- You own the HSA account. If there is a transition of employment, the money and the account goes with you.
- The money in the account can be rolled over from one year to the next, potentially building up thousands of dollars over time if funds are not used. There is no "use it or lose it" feature.
- At age 65, you can use your HSA dollars to pay for any non-qualified medical expenses, however, you won't be eligible to take full advantage of the tax savings as you will be required to pay state and federal taxes on those non-qualified distributions.

Am I eligible to contribute to an HSA

- I am not a dependent on someone else's tax return
- I am not receiving Medicare, VEBA, or TRICARE benefits
- I am covered by a high deductible health plan (HDHP) HSA eligible health plan
- I am not covered under any other type of health insurance plan other than a HDHP (except for insurances specific to injuries, accidents, disability, dental, vision, or long-term care)
- The only FSAs I have, if any, are limited purpose, after-tax, or dependent care

Employee Assistance Program (EAP)

The Employee Assistance Program (EAP) is **available to all employees and their immediate family members,** providing professional, confidential assistance to help individuals resolve concerns that affect their personal lives or work performance. Monroe County cares about you and recognizes that work performance can be affected by problems related and unrelated to your job.

The Employee Assistance Program Can Help

Being able to share a problem can do much to alleviate the stress you may be experiencing. Specially trained EAP consultants are available to help you work through your concerns. Each consultant with the EAP possesses the education, training, and experience necessary to provide high quality EAP assessment, intervention and referral services for you.

Available at No Cost

The Gundersen Health System EAP is a benefit to you sponsored by your employer. Sessions with a consultant are offered at no direct cost to you or your family members. Each covered member can receive up to 5 visits at no cost, and completely confidential. If the issues cannot be resolved within EAP, your EAP consultant can link you with appropriate resources where you can receive ongoing assistance. Many services are available on an ability-to-pay basis or may be covered by your health insurance. You are welcome to use the EAP again should a different situation arise.

Confidential Service

Confidentiality is the foundation of the EAP. No information may be released to any other person about your participation in the program without your written permission. Your participation in the EAP is protected and covered by state and federal laws. Please check with your consultant about the limitations to confidentiality.

Always Here for You

Because problems can arise at any time of the day, EAP is accessible 24 hours a day, seven days a week. EAP office hours are 8:00 a.m. to 5:00 p.m., Monday through Friday with evening appointments available upon request. During regular business hours, the EAP office assistant can assist you with scheduling an appointment or talking with a consultant.

Just a Phone Call Away

If you would like more information about EAP or would like to schedule an appointment, please call (608) 775-4780 or (800) 327-9991. You can also check out the website: **gundersenhealth.org/eap.**

GUNDERSEN HEALTH SYSTEM®

Get Your Wellness on!

In an effort to promote health and wellbeing among Monroe County employees, the Human Resources & Health departments are partnering together to provide a comprehensive employee wellness program that will include education centered on the 8 dimensions of wellness, various wellness activities, and access to resources to help improve overall health and wellbeing.

Monthly Learning Tables

View via Wellable
or
Join us on Zoom

Visit the Wealth in Wellness webpage for information on how to attend each month

Monthly Newsletters

Wellness Activities, Events & Incentives

Wellable platform

Wellness Resources

To learn more & to begin participating visit our Wealth in Wellness webpage.
https://www.co.monroe.wi.us/departments/human-resources/employee-wellness

Flexible Spending Account (FSA)

Health Care & Dependent Care FSA

You can save approximately 28%* of each dollar spent on these expenses when you participate in an FSA.

THE BENEFIT

Medical FSA Plan Year:
January 1st - December 31st

Health Care Max Contribution: $3,200
(subject to change in 2025)

Runout Period: March 31st
Claims Filing Deadline for expenses incurred during the plan year (January 1-December 31)

Contribution Schedule:
Every paycheck (26 paychecks for 2025)

Healthcare FSA Eligible Expenses:

- Medical
- Dental
- Vision

Limited Purpose FSA Eligible Expenses:
(For those contributing to an HSA)

- Dental
- Vision

Dependent Care FSA Limit:
January 1st - December 31st

Dependent Care Max Contribution:
Single/Married filing jointly = $5,000
Married & filing separately= $2,500

(No Rollover for Dependent Care)

Example

How much can I save by using an FSA to pay for braces and childcare? Bob & Jane combined gross income is $60,000. They have two children & file their income taxes jointly. Since Bob & Jane expect to spend $2,000 in orthodontia & $3,000 for daycare, they decide to set aside a total of $5,000 into their FSA account. This example shows their savings by using pre-tax dollars to pay for these known expenses vs. paying for these expenses out of pocket after their income has already been taxed.

	Without FSA	With FSA
You Earn:	$60,000 per year	$60,000 per year
FSA Contribution: You Set Aside (Pre-Tax):	$0 per year	$5,000 per year
After Tax Earnings;	$48,470 per year	$44,466 per year
Dollars spent on dental & childcare expenses for your family	$5,000 per year	$5,000 per year
You Take Home:	$43,470 per year	$44,466 per year
Spendable Income Increases:	→	$996.00 per year

Your personal income and tax savings may vary based on income, tax rate, and the amount you contribute to your FSA account. This example is for illustration purposes only.

Employee Benefits Corporation (EBC) handles the FSA. To contact customer service call 1-800-346-2126, email support at participantservices@ebcflex.com

Scan the QR Code to visit EBC's website: **www.ebcflex.com**

DID YOU KNOW? The Medical FSA dollars are pre-funded, meaning the entire amount you elect is available to use immediately, even though you have not contributed all of it yet. The Dependent Care dollars are NOT pre-funded, meaning the dollars are available as you contribute each pay period. If you are contributing to an HSA account, you can only use the FSA for Limited Purpose; dental, vision and Dependent Care.

You do not have to be enrolled in the Group Medical plan to take advantage of the FSA.

THE Insurance CENTER

OFF-THE-JOB
ACCIDENT INSURANCE

GVAP6 Off the Job Benefit Amounts

Benefits are paid once per accident unless otherwise noted here or in the brochure

Base Policy Benefit	Low Plan	High Plan
Initial Hospital Confinement (pays once/year)	$1,500	$2,000
Daily Hospital Confinement (pays daily)	$300	$400
Intensive Care (pays daily)	$600	$800
Rider Benefit		
Accident Treatment & Urgent Care Rider		
Ambulance — Ground	$300	$400
Ambulance — Air	$900	$1,200
Accident Physician's Treatment	$150	$200
X-ray	$300	$400
Urgent Care	$150	$200
Dislocation/Fracture Rider*	$6,000	$8,000
Emergency Room Services Rider	$300	$400
Outpatient Physician's Treatment for Accident and Preventative Care Benefit Rider	$50	$50
Accidental Death, Dismemberment, and Functional Loss Rider	$60,000	$80,000
Common Carrier (fare-paying passenger)	$150,000	$200,000
Benefit Enhancement Rider		
Accident Follow-Up Treatment (pays daily)	$150	$200
Lacerations	$150	$200
Burns — <15% body surface	$300	$400
Burns — 15% or more	$1,500	$2,000
Skin Graft (% of Burns Benefit)	50%	50%
Brain Injury Diagnosis	$900	$1,200
Computed Tomography (CT) Scan and Magnetic Resonance Imaging (MRI) (pays once/year)	$150	$200
Paralysis (pays once) — Paraplegia	$22,500	$30,000
Paralysis (pays once) — Quadriplegia	$45,000	$60,000
Coma with Respiratory Assistance	$30,000	$40,000
Open Abdominal or Thoracic Surgery	$3,000	$4,000
Tendon, Ligament, Rotator Cuff, or Knee Cartilage Surgery — Surgery	$1,500	$2,000
Tendon, Ligament, Rotator Cuff, or Knee Cartilage Surgery — Exploratory	$450	$600
Ruptured Spinal Disc Surgery	$1,500	$2,000
Eye Surgery	$300	$400
General Anesthesia	$300	$400
Blood and Plasma	$900	$1,200
Appliance	$375	$500
Medical Supplies	$15	$20
Medicine	$15	$20
Prosthesis — 1 device	$1,500	$2,000
Prosthesis — 2 or more devices	$3,000	$4,000
Physical, Occupational, or Speech Therapy (pays daily)	$90	$120
Rehabilitation Unit (pays daily)	$300	$400
Non-Local Transportation	$750	$1,000
Family Member Lodging (pays daily)	$300	$400
Post-Accident Transportation (pays once/year)	$600	$800
Broken Tooth	$300	$400
Residence/Vehicle Modification	$1,500	$2,000
Pain Management (Epidural Injection)	$150	$200
Miscellaneous Outpatient Surgery	$300	$400

*Each benefit pays the amount shown. *Up to amount shown; see Injury Benefit Schedule on reverse. Multiple losses from same injury pay only up to amount shown above.

ALLSTATE ACCIDENT INSURANCE

An accident can wreak havoc on your savings if you are not prepared. That's why there is accident insurance. It gives you a cushion to help cover medical expenses and living costs when you get hurt unexpectedly.

Because it's a supplemental plan, in works in addition to other insurance you may have in place. You can use this policy on its own or to fill a gap left by other coverage such as deductibles and coinsurance. Benefits are paid directly to you as CASH!

Injury Benefit Schedule

Benefit amounts for coverage and one occurrence are shown below.

Complete Dislocation	Low Plan	High Plan
Hip joint	$6,000	$8,000
Knee or ankle joint, bone or bones of the foot	$2,400	$3,200
Wrist joint	$2,100	$2,800
Elbow joint	$1,800	$2,400
Shoulder joint	$1,200	$1,600
Bone or bones of the hand, collarbone	$900	$1,200
Two or more fingers or toes	$420	$560
One finger or toe	$180	$240
Complete, Simple or Closed Fracture		
Hip, thigh (femur), pelvis**	$6,000	$8,000
Skull**	$5,700	$7,600
Arm, between shoulder and elbow (shaft), shoulder blade (scapula), leg (tibia or fibula)	$3,300	$4,400
Ankle, knee cap (patella), forearm (radius or ulna), collarbone (clavicle)	$2,400	$3,200
Foot**, hand or wrist**	$2,100	$2,800
Lower jaw**	$1,200	$1,600
Two or more ribs, fingers or toes, bones of face or nose	$900	$1,200
One rib, finger or toe, coccyx	$420	$560
Loss		
Life, hearing, speech, or both eyes, hands, arms, feet, or legs, or one hand or arm and one foot or leg	$60,000	$80,000
One eye, hand, arm, foot, or leg	$30,000	$40,000
One or more entire toes or fingers	$6,000	$8,000

*Knee join (except patella). Bone or bones of the foot (except toes). Bone or bones of the hand (except fingers). **Pelvis (except coccyx). Skull (except bones of the face or nose). Foot (except toes). Hand or wrist (except fingers). Lower jaw (except alveolar process).

OFF-THE-JOB
ACCIDENT INSURANCE

THE Insurance CENTER

DON'T FORGET!

OUTPATIENT PHYSICIAN'S TREATMENT

$50 benefit will be paid per visit if a covered person has a doctor office visit for any preventative cause.

Reimbursements Pay Out Every Calendar Year

2 visits per person
4 visits per family

Please refer to "How To File A Claim" in the back of your benefit booklet.

Example High Plan

Susie's daughter Ella is playing outside and falls off a swing resulting in a broken arm. How would the Accident plan help Susie?

Occurrence/Service	Benefit Payment
Ambulance	$400
ER Visit	$400
Accident Physician's Treatment	$200
X-Ray	$400
Appliance Benefit	$500
Fractured Forearm	$3,200
Medicine Benefit	$20
Medical Supplies Benefit	$20
Accident Follow Up Visit	$200
Physical Therapy Benefit	$120
TOTAL BENEFIT =	**$5,460**

Low Plan	Semi-Monthly Gross Cost	*Net Cost	Annual *Net Cost	Outpatient Physician** Reimbursement	Annual Cost After Outpatient Reimbursement	Per Semi-Monthly Cost After Reimbursements
Member Only	$8.00	$5.76	$138.24	($100)	$38.24	$1.59
Member/Spouse	$13.82	$9.95	$238.81	($200)	$38.81	$1.62
Member/Child(ren)	$20.52	$14.77	$354.59	($200)	$154.59	$6.44
Family	$26.70	$19.22	$461.38	($200)	$261.38	$10.89

High Plan	Semi-Monthly Gross Cost	*Net Cost	Annual *Net Cost	Outpatient Physician** Reimbursement	Annual Cost After Outpatient Reimbursement	Per Semi-Monthly Cost After Reimbursements
Member Only	$10.16	$7.32	$175.56	($100)	$75.56	$3.15
Member/Spouse	$17.57	$12.65	$303.61	($200)	$103.61	$4.32
Member/Child(ren)	$26.38	$18.99	$455.85	($200)	$255.85	$10.66
Family	$34.08	$24.54	$588.90	($200)	$388.90	$16.20

***Approximately 28% savings due to Pre-Tax premium**

****OUTPATIENT PHYSICIAN'S TREATMENT & PREVENTIVE CARE BENEFIT:**
(Office Visits, Dental Office Visits, Vision exams, etc)
Member only: 2 at $50= $100
Member/Spouse/Children: 4 at $50 = $200

Outpatient Physicians **Treatment Annually**

The Need For
CANCER INSURANCE

THE Insurance CENTER

Allstate Cancer Insurance: Protection for the treatment of cancer and 29 specified diseases.
Because Cancer Insurance is supplemental, it works in addition to other insurance you may have. You can use the policy on its own or to fill a gap left by your other coverage such as deductibles and coinsurance. Benefits are paid directly to you as CASH!

Benefit Amounts:

Hospital Confinement and Related Benefit	Low	Medium	High
Continuous Hospital Confinement (daily)	$200	$200	$300
Government or Charity Hospital (daily)	$200	$200	$300
Private Duty Nursing Services (daily)	$200	$200	$300
Extended Care Facility (daily)	$200	$200	$300
At Home Nursing (daily)	$200	$200	$300
Hospice Care Center (daily) or Hospice Care Team (per visit)	$200 $200	$200 $200	$300 $300
Radiation/Chemotherapy & Related Benefits			
Radiation/Chemotherapy for Cancer* (every 12 months)	$5,000	$10,000	$15,000
Blood, Plasma, and Platelets* (every 12 months)	$5,000	$10,000	$15,000
Medical Imaging*	$250	$500	$750
Hematological Drugs*	$100	$200	$300
Surgery and Related Benefits			
Surgery**	$1,500	$3,000	$3,000
Anesthesia (% of surgery)	25%	25%	25%
Ambulatory Surgical Center (daily)	$250	$500	$500
Second Opinion	$200	$400	$400
Bone Marrow and Stem Cell Transplant 1. Autologous 2. Non-autologous (cancer or specified disease treatment) 3. Non-autologous (Leukemia)	 $500 $1,250 $2,500	 $1,000 $2,500 $5,000	 $1,000 $2,500 $5,000

Miscellaneous Benefits	Low	Medium	High
Inpatient Drug and Medicine (daily)	$25	$25	$25
Physician's Attendance (daily)	$50	$50	$50
Non-Local Transportation* (per trip or mile)	Coach Fare or $0.40/mi	Coach Fare or $0.40/mi	Coach Fare or $0.40/mi
Outpatient Lodging (daily)	$50	$50	$50
Family Member Lodging (daily) and Transportation* (per trip or mile)	$50 Coach Fare or $0.40/mi	$50 Coach Fare or $0.40/mi	$50 Coach Fare or $0.40/mi
Physical or Speech Therapy (daily)	$50	$50	$50
New or Experimental Treatment** (every 12 months)	$5,000	$5,000	$5,000
Prosthesis***	$2,000	$2,000	$2,000
Hair Prosthesis (every 2 years)	$25	$25	$25
Nonsurgical External Breast Prosthesis*	$50	$50	$50
Anti-Nausea Benefit*	$200	$200	$200
Waiver or Premium (employee only)	Yes	Yes	Yes
Additional Benefits			
Cancer Initial Diagnosis	$2,000	$2,000	$5,000
Wellness Benefit	$100	$100	$100
Intensive Care 1. Intensive Care Confinement (daily) 2. Step-down Confinement (daily) 3. Air/Surface Ambulance	 $200 $100 Charges	 $200 $100 Charges	 $600 $300 Charges

It is estimated that:

1 in 2 men will be diagnosed with Cancer at some point in their life

Estimated New Cases In 2023 — Males

Prostate	288,300	29%
Lung & bronchus	117,550	12%
Colon & rectum	81,860	8%
Urinary bladder	62,420	6%
Melanoma of the skin	58,120	6%
Kidney & renal pelvis	52,360	5%
Non-Hodgkin lymphoma	44,880	4%
Oral cavity & pharynx	39,290	4%
Leukemia	35,670	4%
Pancreas	33,130	3%
All Sites	**1,010,310**	**100%**

1 in 3 women will be diagnosed with Cancer at some point in their life

Females — **Estimated New Cases In 2023**

Breast	297,790	31%
Lung & bronchus	120,790	13%
Colon & rectum	71,160	8%
Uterine corpus	66,200	7%
Melanoma of the skin	39,490	4%
Non-Hodgkin lymphoma	35,670	4%
Thyroid	31,180	3%
Pancreas	30,920	3%
Kidney & renal pelvis	29,440	3%
Leukemia	23,940	3%
All Sites	**948,000**	**100%**

The Need For
CANCER INSURANCE

THE Insurance CENTER

Example:

Kelly is diagnosed with cancer. She undergoes pre-op medical imaging and is admitted to the hospital for surgery. She has a 3 day stay in the hospital. Every 2 weeks Kelly has chemo treatments. How would the Cancer plan help Kelly?

Occurrence/Service	Benefit Payment
Cancer Initial Diagnosis	$2,000
Surgery	$3,000
Anesthesia	$750
Radiation/Chemo	$10,000
Medical Imaging	$500
Physicians Visits	$50
Anti-Nausea	$200
TOTAL BENEFIT =	**$16,500**

ADDITIONAL COVERAGE- SPECIFIED DISEASES

29 Specified Diseases Covered under this plan: Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease), Muscular Dystrophy, Poliomyelitis, Multiple Sclerosis, Encephalitis, Rabies, Tetanus, Tuberculosis, Osteomyelitis, Diphtheria, Scarlet Fever, Cerebrospinal Meningitis, Brucellosis, Sickle Cell Anemia, Thalassemia, Rocky Mountain Spotted Fever, Legionnaires' Disease, Addison's Disease, Hansen's Disease, Tularemia, Hepatitis (Chronic B or CI), Typhoid Fever, Myasthenia Gravis, Reye's Syndrome, Primary Sclerosing Cholangitis (Walter Payton's Disease), Lyme Disease, Systemic Lupus Erythematosus, Cystic Fibrosis, and Primary Biliary Cirrhosis

DON'T FORGET!

Annual Wellness Benefit

$100 Benefit will be paid per person, per calendar year, for a specified wellness screening/test.

ELIGIBLE WELLNESS SCREENINGS/TEST

- **Lipid Panel**
- **Blood test for Triglycerides**
- **Biopsy for Skin Cancer**
- **Cholesterol**
- **Mammogram**
- **Blood test for Breast Cancer**
- **Blood test for Ovarian Cancer**
- **Blood test for Colon Cancer**
- **Blood test for Prostate Cancer (PSA)**
- **Bone Marrow Testing**
- **Chest X-Ray**
- **Colonoscopy**
- **EKG**
- **HPV Vaccination**
- **Pap Smear**
- **Stress Test**
- **Echocardiogram**
- **Serum Protein (Myeloma)**
- **Thermography**

Cancer Insurance Semi-Monthly Cost (Example: Medium Plan)

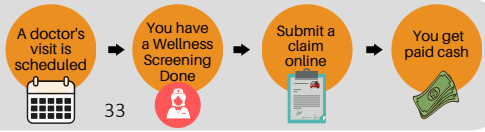
See enrollment form for Low and High Plan options, semi-monthly cost

	Gross Cost	*Net Cost	*Net Annual Cost	Wellness Reimbursement	Annual Net After Wellness	Per Paycheck *Net Cost After Wellness
Member Only	$12.18	$8.77	$210.47	($100)	$110.47	$4.60
Member/Spouse	$19.03	$13.70	$328.84	($200)	$128.84	$5.37
Member/Child(ren)	$17.05	$12.28	$294.62	($100) ($200) ($300)**	$194.62 $94.62 -$5.38	$8.11 $3.94 -$0.22
Family	$23.89	$17.20	$412.82	($200) ($300)**	$212.82 $112.82	$8.87 $4.70

*Approximate 28% Savings due to Pre-Taxing the premium

**Payable once/covered person/calendar year

Annual Wellness Benefit



THE Insurance CENTER

Your Options For
CRITICAL ILLNESS INSURANCE

Allstate Critical Illness Insurance

INITIAL CRITICAL ILLNESS BENEFITS	Plan 1	Plan 2
Heart Attack (100%)	$10,000	$20,000
Stroke (100%)	$10,000	$20,000
End Stage Renal Failure (100%)	$10,000	$20,000
Major Organ Transplant (100%)	$10,000	$20,000
Coronary Artery Bypass Surgery (25%)	$2,500	$5,000
Waiver of Premium (employee only)	Yes	Yes
REOCCURRENCE OF CRITICAL ILLNESS BENEFITS	**Plan 1**	**Plan 2**
Initial Critical Illness (same amount as Initial Critical Illness Benefit)	Yes	Yes
RIDER BENEFITS	**Plan 1**	**Plan 2**
Cardiopulmonary Enchancement Rider		
Sudden Cardiac Arrest (25%)	$2,500	$5,000
Pulmonary Embolism (25%)	$2,500	$5,000
Pulmonary Fibrosis (25%)	$2,500	$5,000
Lifestyle Enhancement Rider	$25	$25
Second Evaluation, Transportation and Lodging Rider		
Second Evaluation	$1,000	$1,000
Non-Local Transportation Air Fare Personal Vehicle	$500 or $0.50/mile	$500 or $0.50/mile

RIDER BENEFITS CONTINUED	Plan 1	Plan 2
Outpatient Lodging (daily)	$100	$100
Family Member Lodging	$100	$100
Family Member Transportation Air Fare Personal Vehicle	$500 or $0.50/mile	$500 or $0.50/mile
Supplemental Critical Illness Rider		
Advanced Alzheimer's Disease (100%)	$10,000	$20,000
Advanced Parkinson's Disease (100%)	$10,000	$20,000
Benign Brain Tumor (100%)	$10,000	$20,000
Coma (100%)	$10,000	$20,000
Complete Loss of Hearing (100%)	$10,000	$20,000
Complete Loss of Sight (100%)	$10,000	$20,000
Complete Loss of Speech (100%)	$10,000	$20,000
Paralysis (100%)	$10,000	$20,000

Specified Chronic Illness Rider:
Must be certified by a physician as having of the chronic illnesses listed to below. Must be unable to perform at least two daily activities for at least 90 days. (Adrenal Hypofunction (Addison's Disease), Lou Gehrig's Disease (ALS), Arthritis, Huntington's Chorea, Multiple Sclerosis, Muscular Dystrophy, Osteomyelitis, Osteoporois)

2 Deductions Per Month (10K) Benefit

Uni-Tobacco*				
	Emp	Emp+Sp	Emp+Ch	Family
18-29	$1.92	$3.26	$1.92	$3.26
30-39	$3.12	$5.10	$3.12	$5.10
40-49	$5.52	$8.77	$5.52	$8.77
50-59	$9.48	$14.83	$9.48	$14.83
60-64	$12.93	$20.07	$12.93	$20.07
64+	$21.87	$33.56	$21.87	$33.56

*Prices above are indicated as post-tax premiums.

2 Deductions Per Month (20K) Benefit

Uni-Tobacco*				
	Emp	Emp+Sp	Emp+Ch	Family
18-29	$3.09	$5.00	$3.09	$5.00
30-39	$5.42	$8.53	$5.42	$8.53
40-49	$10.03	$15.53	$10.03	$15.53
50-59	$17.74	$27.21	$17.74	$27.21
60-64	$24.50	$37.42	$24.50	$37.42
64+	$42.26	$64.13	$42.26	$64.13

Allstate How to File a Claim

Accident Preventative & Cancer Wellness

Secure Online Benefits Access

MyBenefits

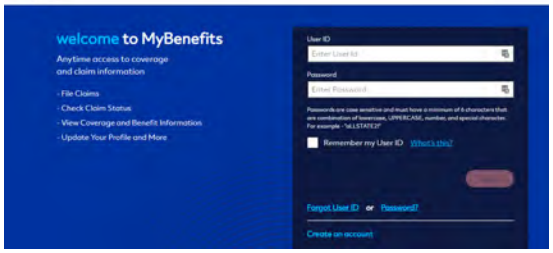
Manage Your Account and File Claims through your MyBenefits portal

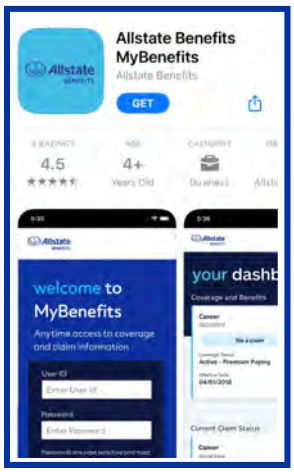
E-Signature	Direct Deposit	View	Download
Upload, review and sign your claim electronically	Available for faster processing	Full policies, certificates and claim history	Explanation of Benefits (EOB)

1 Scan the QR code below to access MyBenefits on your computer, mobile device or download the MyBenefits App. Sign up for access using the secure online registration process and create a user ID and password, then Log in.

Allstate BENEFITS

www.allstatebenefits.com/mybenefits

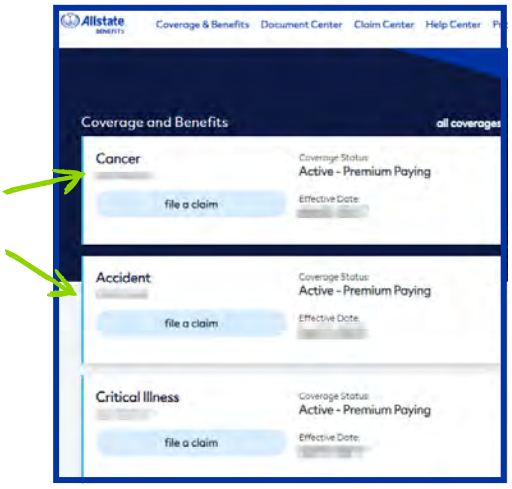




GET IT ON Google Play

Download on the App Store

2 Select the type of claim you want to file: Cancer offers the Wellness screening reimbursement. The Accident plan offers the Outpatient Physician's Treatment/Preventative reimbursement.



3 Elect which type of claim you are filing

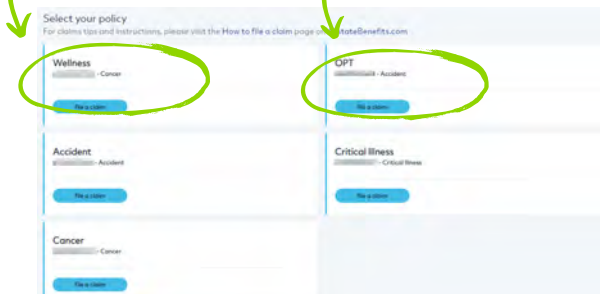
Eligible Wellness Screenings (Tests)

- Lipid Panel
- Cholesterol
- Pap
- Mammogram
- Colonoscopy
- Prostate Exam
- HPV Vaccination

.....and many more

Outpatient Physician's Treatment (Preventative Exams)

- Dental Exams
- Preventative Exam (Well Adult, Well Child Visits)
- Annual Preventative Eye Exam



Need more help?

Scan the QR code to watch a short video on how to file a claim by using the **Allstate App.**

For claims tips and instructions, please visit www.allstatebenefits.com/Individuals/HowToFileClaim. If you prefer to file a paper claim or have any other questions, contact HR, The Insurance Center, or Allstate (800) 348-4489. Additional claim forms can be found on Allstate's portal as well.

2025 Government Notices

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS
**** CONTINUATION COVERAGE RIGHTS UNDER COBRA****

Note: *Federal COBRA applies to group health plans maintained by private-sector, state, and local government employer with 20 or more employees. Group health plans sponsored by the federal government or churches are exempt from COBRA. For Wisconsin employers, State Continuation applies to insured group health plans providing medical/hospital coverage. Dental, vision, and prescription drug benefits are not subject to state continuation if they are offered as separate policies. Employer self-funded plans are not subject to these requirements. Outside of Wisconsin -refer to your state specific laws or carrier for further information.*

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

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

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

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage may be required to pay for COBRA continuation coverage. Your employer will provide you with the information should you experience a qualifying event.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies.
- Your spouse's hours of employment are reduced.
- Your spouse's employment ends for any reason other than his or her gross misconduct.
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.
- Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:
- The parent-employee dies.
- The parent-employees' hours of employment are reduced.
- The parent-employee's employment ends for any reason other than his or her gross misconduct.
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both).
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

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

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

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

How is COBRA Continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended.

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

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

Are there other coverage options besides COBRA Continuation coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA Continuation coverage after my group health plan coverage ends?
In general, if you do not enroll in Medicare Part A or B when are you first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

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

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

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer), and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit https://www.medicare.gov/medicare-and-you.

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

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

Plan Contact Information: Your employer's Human Resource Department or individual in charge of Benefits Administration within your organization.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator for more information.

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers from requesting or requiring genetic information of an individual or family member, except as specifically allowed by law. To comply with this law, we are asking that you **not** provide any genetic information when responding to any request for medical information unless it is necessary to comply with enrollment and does not apply to Life, disability or long term. Genetic information is defined as: Information about an individual's and family genetic tests,

- Family medical history.
- Requests for and receipt of genetic services by the individual or family members.
- Genetic information of a fetus carried by an individual or family member or information of any embryo legally held by the individual or family member using assisted reproductive technology.

NOTICE OF PATIENT PROTECTIONS

Under the ACA, group health plans and issuers that require the designation of a participating primary care provider must permit each participant, beneficiary and enrollee to designate any available participating primary care provider (including a pediatrician for children). Additionally, plans and issuers that provide obstetrical/gynecological care and require a designation of a participating primary care provider may not require preauthorization or referral for such care. If a health plan requires participants to designate a participating primary care provider, the plan or issuer must provide a notice of these patient protections whenever the SPD or similar description of benefits is provided to a participant. If your employer's plan is subject to this notice requirement, they will provide this information in the open enrollment materials and/or the Summary Plan Description (SPD).

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, 2024. Contact your State for more information on eligibility –

IOWA – Medicaid Website: Iowa Medicaid | Health & Human Services Phone: 1-800-338-8366 **CHIP (Hawki): Hawki - Healthy and Well Kids in Iowa | Health & Human Services** Phone: 1-800-257-8563. HPP Website Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562

WISCONSIN – Medicaid and CHIP Website: https: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

MINNESOTA – Medicaid https://mn.gov/dhs/health-care-coverage Phone: 1-800-657-3672

To see if any other states have added a premium assistance program since July 31, 2024, 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

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. Expires 01/31/2026

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE:

When key parts of the health care law took effect in 2014, there is 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.

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. The open enrollment period each year for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the preceding year. After the open enrollment period ends, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 8.39% (2024) and 9.02% (2025) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

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

How Can I Get More Information?
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.

HIPAA PRIVACY INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

This *simplified notice* describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated
- You can complain if you feel we have violated your rights by contacting your HR Department
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **ww.hhs.gov/ocr/privacy/hipaa/complaints**

We will not retaliate against you for filing a complaint.

Our Uses and Disclosures:
Help manage the health care treatment you receive:
We can use your health information and share it with professionals who are treating you. *Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

Run Our Organization:
We can use and disclose your information to run our organization and contact you when necessary. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. *Example: We use health information about you to develop better services and plan design for our company.*

Pay for Your Health Services:
We can use and disclose your health information as we pay for your health services. *Example: We share information about you with your dental plan to coordinate payment for your dental work.*

Administer your Plan:
We may disclose your health information to your health plan sponsor for plan administration. *Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

How Else can we use or Share your Health Information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Our Responsibilities:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, or you can request we mail a copy to you. This is a summary of information only.

CONSOLIDATED APPROPRIATIONS ACT DISCLOSURE FOR PLAN MEMBERS

The Consolidated Appropriations Act (CAA) is a comprehensive set of laws that include the No Surprises Act (NSA) and transparency provisions. Plan Sponsors are required to post an NSA Notice in a prominent location in the workplace and/or post a link to the NSA Notice on the searchable home page of their websites. The Department of Labor (DOL) has provided a model notice, which should be used for plan years beginning on or after January 1, 2022.

Your Rights and Protections Against Surprise Medical Bills

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

What is "Balance Billing" (sometimes called "surprise billing")?
When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or must pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

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

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

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

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

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

When Balance Billing isn't Allowed, you also have the Following Protections:

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

If you believe you've been wrongly billed, you may contact the Department of Health and Human Services to reach the entity responsible for enforcing the federal balance or surprise billing protection laws at 1-800-985-3059.
Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

Monroe County
Human Resources Department

Questions? Feel free to contact your Human Resources Department!

Ed Smudde
(608) 269-8719
ed.smudde@co.monroe.wi.us

Hannah Olsen
(608) 269-8720
hannah.olsen@co.monroe.wi.us

Or view additional information on the Monroe County Employee Benefits website at:
https://www.co.monroe.wi.us/departments/human-resources/employee-benefits

Or scan the QR Code:

Or scan the QR Code:

Interested in learning more on Monroe County's Wellness Program, visit the website at:
https://www.co.monroe.wi.us/departments/human-resources/employee-wellness

THE Insurance CENTER

Your Service Team

Garrett Jerue
Corporate Benefits Sales Manager
D: 800.944.1367 ext. 30116
F: 608.783.6431
E: gjerue@ticinsurance.com

Rick Tischer
Corporate Benefits Specialist
P: 800.944.1367 ext. 30154
F: 608.783.6431
E: rtisher@ticinsurance.com

Heather Gerken
Client Success Specialist
D: 800.944.1367 ext. 30125
F: 608.783.6431
E: hgerken@ticinsurance.com

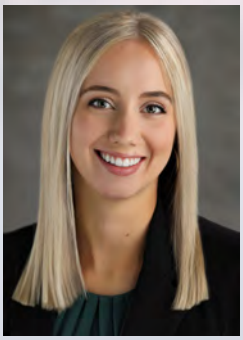
Laura Grana
Account Support Representative
D: 800.944.1367 ext. 30236
F: 608.783.6431
E: lgrana@ticinsurance.com

Jennifer Capaul
Support Leader
D: 800.944.1367 ext. 30137
F: 608.783.6431
E: jcapaul@ticinsurance.com

Amanda Running
Client Success Specialist II
D: 800.944.1367 ext. 30125
F: 608.783.6431
E: arunning@ticinsurance.com

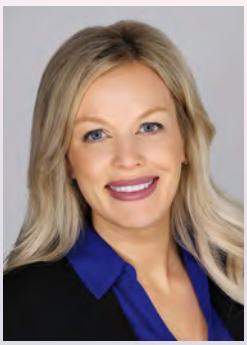
Kim Beckman
Client Success Specialist II
D: 800.944.1367 ext. 30235
F: 608.783.6431
E: kbeckman@ticinsurance.com

Missy Hundt
Core Account Consultant
D: 800.944.1367 ext. 30145
F: 608.783.6431
E: mhundt@ticinsurance.com



Tia Olson
Account Support Representative
D: 800.944.1367 ext. 30128
F: 608.783.6431
E: tolson@ticinsurance.com

Patsy LaBarbara
Account Support Representative
D: 800.944.1367 ext. 30158
F: 608.783.6431
E: plabarbara@ticinsurance.com



Jill Ekern
Account Support Rep
D: 800.944.1367 ext. 30129
F: 608.783.6431
E: jekern@ticinsurance.com

Shannon Loveless
Account Support Rep
D: 800.944.1367 ext. 30161
F: 608.783.6431
E: sloveless@ticinsurance.com

701 Sand Lake Road
Onalaska, WI 54650

THE Insurance CENTER