# 2025

# BENEFITS GUIDE


Gage

# What I Need to Know?

## Who Is Eligible?

Employees with Gage Marine are eligible to enroll in the benefits outlined in this guide if working 30 hours or more per week. In addition, your dependents (spouse, natural or adopted child, grandchild, or child for whom you have legal guardianship) are eligible for these benefits.

## How To Enroll?

Are you ready to enroll? All of your new hire benefit elections, as well as open enrollment elections, will be made in iSolved's enrollment portal.

The decisions you make during your initial enrollment and/or 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. **The benefits run on Calendar year, January 1st - December 31st of each year.**

New employees are eligible for benefits on the 1st day of the month following 30 days of employment.

## When Can I Make Changes Outside of Open Enrollment?

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.

# Your Benefits

| BENEFITS | CARRIER | WHO CONTRIBUTES | PREMIUM TAX TREATMENT |
|---|---|---|---|
| Medical Insurance | Allegiance | You & Gage Marine | Pre-tax |
| Health Savings Account (HSA) | Bank of Choice | You | Pre-tax |
| Dental Insurance | Delta Dental | You | Pre-tax |
| Vision Insurance | Delta Vision/EyeMed | You | Pre-tax |
| Life Insurance | Humana | Gage Marine | N/A |

## 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.

# Health Insurance

## COPAY PLAN

Gage Marine offers two comprehensive Health Plan options to choose from, an HSA Plan and a Copay Plan. Below are the benefits outlined under the Copay Plan.

| COVERAGE | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| DEDUCTIBLE *(Embedded) | $1,000 Individual<br>$2,000 Family | $3,000 Individual<br>$6,000 Family |
| COINSURANCE | 80% Gage Marine / 20% Employee | 60% Gage Marine/ 40% Employee |
| MAXIMUM OUT-OF-POCKET (Medical & Rx Combined) | $4,000 Individual<br>$8,000 Family | $12,000 Individual<br>$24,000 Family |
| PREVENTIVE CARE Well Adult/Well Child and Annual Eye Exam | Covered 100% by Insurance | Price Charged goes towards Deductible then Coinsurance |
| VIRTUAL VISITS (Through Recuro Health) | No Cost through Recuro Health | |
| OFFICE VISIT | $30 Copay | Covered 60% after Deductible |
| CHIROPRACTIC (Limit of 30 visits) | $30 Copay | Covered 60% after Deductible |
| SPECIALIST VISIT | $60 Copay | Covered 60% after Deductible |
| URGENT CARE | $100 Copay | Covered 60% after Deductible |
| EMERGENCY ROOM | $250 Copay | $250 Copay |
| PRESCRIPTION BENEFIT<br>Retail = 30 day supply<br>Mail Order = 90 day supply | Tier 1: $10 Copay ($25 Mail Order)<br>Tier 2: $35 Copay ($97.50 Mail Order)<br>Tier 3: $60 Copay ($150 Mail Order)<br>Specialty: $250 Copay | |

*Embedded: With an embedded deductible, 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.

# Health Insurance

## HSA PLAN

Gage Marine offers two comprehensive Health Plan options to choose from, an HSA Plan and a Copay Plan. Below are the benefits outlined under the HSA Plan. Enrolling in this plan also allows the ability to contribute pre-tax earrings into an HSA account.

| COVERAGE | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| DEDUCTIBLE *(Embedded) | $3,300 Individual<br>$6,600 Family | $6,400 Individual<br>$12,800 Family |
| COINSURANCE | 100% | 60% Gage Marine / 40% Employee |
| MAXIMUM OUT-OF-POCKET (Medical & Rx Combined) | $3,300 Individual<br>$6,600 Family | $8,000 Individual<br>$16,000 Family |
| PREVENTIVE CARE Well Adult/Well Child and Annual Eye Exam | Covered 100% by Insurance | Price Charged goes towards Deductible then Coinsurance |
| VIRTUAL VISITS (Through Recuro Health) | $40 through Recuro Health | |
| OFFICE VISIT | Price Charged goes towards Deductible, then covered 100% | Price Charged goes towards Deductible then Coinsurance |
| CHIROPRACTIC (limit of 30 visits) | Price Charged goes towards Deductible, then covered 100% | Price Charged goes towards Deductible then Coinsurance |
| SPECIALIST VISIT | Price Charged goes towards Deductible, then covered 100% | Price Charged goes towards Deductible then Coinsurance |
| URGENT CARE | Price Charged goes towards Deductible, then covered 100% | Price Charged goes towards Deductible then Coinsurance |
| EMERGENCY ROOM | Price Charged goes towards Deductible, then covered 100% | Price Charged goes towards Deductible then Coinsurance |
| PRESCRIPTION BENEFIT | Price Charged goes towards Deductible then covered 100%<br>***Includes $0 Preventative Drug List*** | |

*Embedded: With an embedded deductible, 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.

# HealthCARE At No Cost To You

## Costs covered by Gage Marine

the DOCTOR'S OFFICE

# Our Services

No Cost to ALL Employees!

Offered to Spouses and Dependents of those only on the health plan.

We perform physicals, provide immunizations, and treat illnesses and injuries at our Wisconsin offices.

Services vary by location. Please call to confirm availability.

### Services Will Vary Based On Location

**Office Visit**

- Family Practice
- Women's Health
- Pap
- Pediatrics
- School/Sports Physicals
- Health Coaching & Nutritional Counseling

**Additional Services**

- Select Medicine Dispensed
- Physical Therapy
- Occupational Therapy
- Wellness Coaching
- X-rays
- Minor Trauma (suturing)

**Lab Work**

- A1c
- CBC
- Metabolic Panel
- Lipid Panel
- Influenza A&B
- Strep
- Vaccinations

**Non Covered Services**

- Counseling Services
- Chiropractic
- Massage Therapies/Hot Stones
- Facial Rejuvenation
- Acupuncture
- Life/Business Coaching
- Mental Health Services

## Locations

Darien, Wisconsin

P: 262-725-3331
M-Th 8:00-6:00
F-Sa 8:00-2:00

Brookfield, Wisconsin

P: 414-455-0463
M-Th 8:00-5:00
F-Sa 8:00-12:00

Janesville, Wisconsin

P: 608-713-0472
M-Th 8:00-5:00
F-Sa 8:00-12:00

Cedarburg, Wisconsin

P: 262-421-9911
M-Th 8:00-5:00
F-Sa 8:00-12:00

Burlington, Wisconsin

P: 262-757-4131
M-Th 8:00-5:00
F-Sa 8:00-12:00

# 2025 Health Plan Costs

| Employee | Copay | HSA |
|---|---|---|
| Semi-Monthly Payroll Deduction: | $146.91 | $81.08 |

| Employee & Spouse | Copay | HSA |
|---|---|---|
| Semi-Monthly Payroll Deduction: | $342.80 | $273.83 |

| Employee & Child(ren) | Copay | HSA |
|---|---|---|
| Semi-Monthly Payroll Deduction: | $296.06 | $205.40 |

| Family | Copay | HSA |
|---|---|---|
| Semi-Monthly Payroll Deduction: | $498.62 | $345.93 |

# Important Health Plan Information

## MEDICAL NETWORKS

**Main Network:**

The Alliance Self-Funding Smart | Trilogy Health Solutions

**The Alliance/Trilogy Networks**
www.The-Alliance.org

**National Wrap Network:**

Cigna

(network utilized for locations outside of Wisconsin)
www.Cigna.com
Choose: OAP/Open Access Plus, OA Plus, Choice Fund OA Plus

## CARE ADVOCACY

alithias

**Alithias Care Advocacy Team:**
Call: 1-855-270-2850
askme@careadvocacycenter.com

Let Alithias assist with any benefit questions, EOB explanation, billing questions, verifying in-network providers and most importantly, navigating through non-emergent services to find the highest quality, lowest cost providers for services such as:

- **MRI**
- **CT Scan**
- **Colonoscopy**
- **At Home Sleep Studies**
- **Breast Biopsy**
- **Hysterectomy**
- **Orthopedic Procedures**
- **Out-Patient Surgeries**

(See full list of services and Incentive payouts on the following pages)

## PRESCRIPTION

NAVITUS HEALTH SOLUTIONS

**Navitus Customer Service 24/7 Support:**
**1-855-673-6504**
www.Navitus.com

**Mail Order**
**1-800-481-4940**
www.serve-you-rx.com

**Prescription Drug Benefits are provided through Navitus Health Solutions.**

Any Specialty Drugs must be purchased through Lumicera Specialty Pharmacy, 1-855-847-3553.

**Preventative Drugs are covered by the plan before reaching the deductible. Please refer to the health plan document (SPD) for details.**

## TPA
Third Party Administrator

Allegiance℠ by Cigna Healthcare

**Medical Claims Processor**
**Please reach out to Allegiance for:**

- Provider Verification
- Claims Questions
- Medical ID card
- Explanation of Benefits (EOB)
- Prior Authorization
- Case Management

1-855-999-7781
www.askallegiance.com

Available on the App Store | Google Play

# 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.

## HowTo Research Healthcare Cost &Quality

...And Possibly Get A Cash Incentive!

**Call an Alithias Care Advocacy for:**

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

**Step 1**

**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 manager for more details.

***You can email us here:***

askme@careadvocacycenter.com

# Incentives for Being A Good HealthCARE Consumer!

## 2025 Alithias Procedure Incentive Offerings

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:**<br>• Smart Infusion<br>• OSMS Green Bay<br>• 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 Procedure Incentive Offerings

| 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 Copay 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

# Your Mental Health Support

## Helping You Thrive

Everyone experiences challenges that can affect their mental health. Your employer offers a benefit called an Employee Assistance Program (EAP) through ERC: Counselors & Consultants that can help you address mental health issues and create positive ripples in your life.

- The EAP provides short-term mental health counseling for you (employees), your spouse, your dependents, and those in your immediate household.
- There is no cost or co-pay to use the program, and the EAP is not tied to your insurance. Your employer sponsors this mental health benefit.
- EAP counseling is confidential and HIPAA protected. No identifying information is provided to your employer without your written consent.
- ERC has a team of licensed counselors as well as a proprietary network of counselors throughout the nation to assist you where you are located.

## This service offers 8 sessions per condition

### How to Use Your Employee Assistance Program

#### Recognize an Issue

The EAP can help you address relationship and family issues, stress, anxiety, depression, grief, alcohol abuse, and other mental health concerns.

#### Schedule an Appointment

Call 1-800-222-8590 to make an appointment with a counselor. Your free and confidential EAP benefit can include telephonic, video, or face-to-face counseling (where available).

#### Talk with a Counselor

During your counseling sessions, you and your counselor will talk about your concerns and develop an ongoing plan for meeting your mental health goals.

For in-the-moment mental health support, call the EAP anytime. For emergencies or imminent danger to yourself or others, please call 911, 988 for the national Suicide and Crisis Lifeline, or your local crisis center.

ERC
COUNSELORS & CONSULTANTS

There is one number to call, and it is answered 24/7/365.

## Call 1-800-222-8590

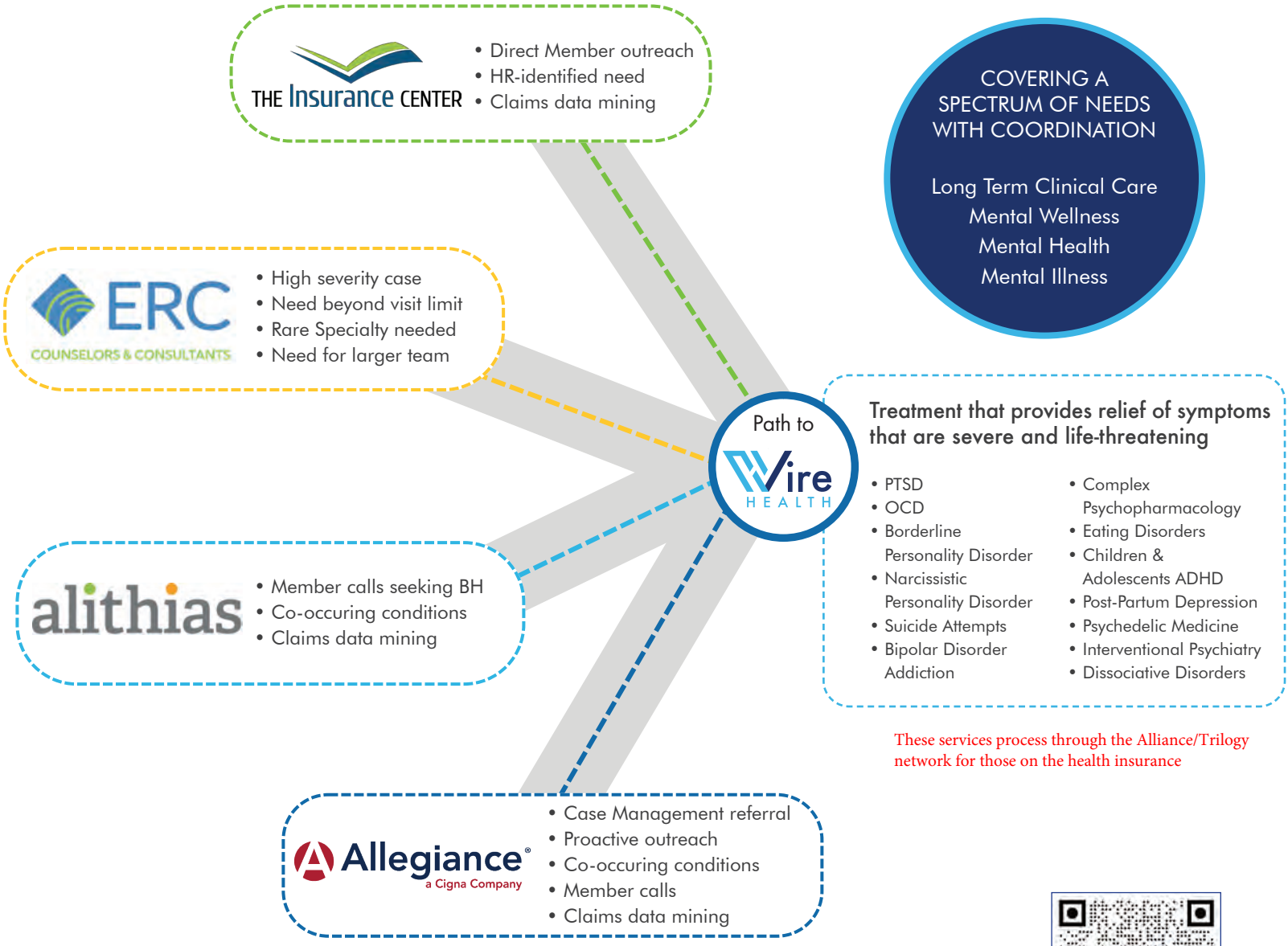
Appointment Scheduling Hours:
Monday–Thursday 8 a.m. to 5 p.m. (CST) Friday 8 a.m. to 2 p.m. (CST)

# 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




These services process through the Alliance/Trilogy network for those on the health insurance

**Call**
Care Navigators
855-270-2850

**Text**
Wire Health
414-626-0120

**Scan**
our QR Code

https://wire.health

# 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

Allegiance℠
by Cigna Healthcare

# Maternity Management

## Personal Support for a Smooth & Healthy Pregnancy

The Allegiance Maternity Management Program offers assistance and support for members who are pregnant at no additional cost. The program provides you with ongoing one-on-one care and expertise throughout your pregnancy.

When you sign up, your personal maternity nurse will be available to share education and resources to ensure a healthy and low-stress pregnancy. After your baby is born, your nurse will continue to be a resource for you during those crucial first few weeks as a new parent.

Everyone's pregnancy, delivery, and postpartum needs and challenges are different. With the Allegiance Maternity Management Program, you can feel secure knowing we're with you every step of the way.

**This program is available at no cost to you - in fact, your employer has set up a bonus for participating!**

## Incentive

If you register within the first or second trimester of your pregnancy, you will receive a **gift card** upon completion of the program. $50 if enrolling in the 1st Trimester or $50 if enrolling in the 2nd trimester.

- Register as early in your pregnancy as possible
- Check in with your nurse regularly throughout your pregnancy
- Complete the Post Pregnancy Assessment

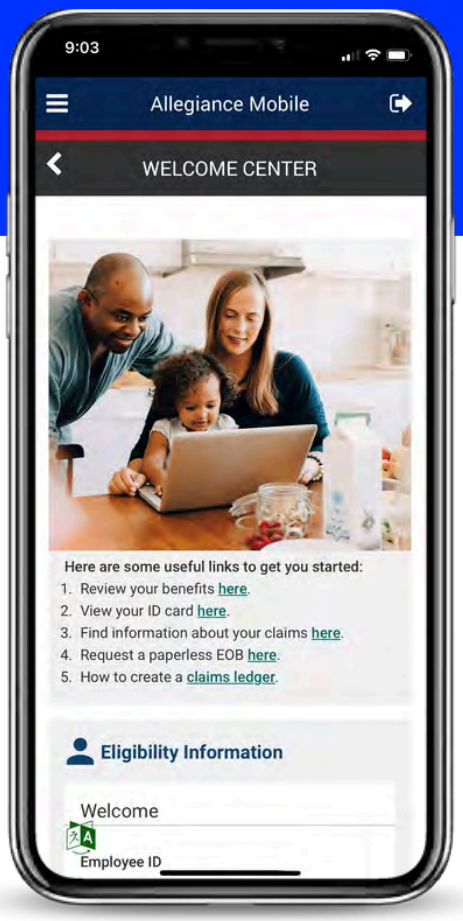
Sign up online by completing the enrollment form at www.askallegiance.com/Resources/MaternityManagementRequest

For more information, questions, or to enroll by phone, call the Allegiance Care Management Nurse at 1-877-792-7827 ext. 1.

# Allegiance Mobile App

Allegiance℠ by Cigna Healthcare

**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

Download on the App Store

GET IT 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.

# 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.**

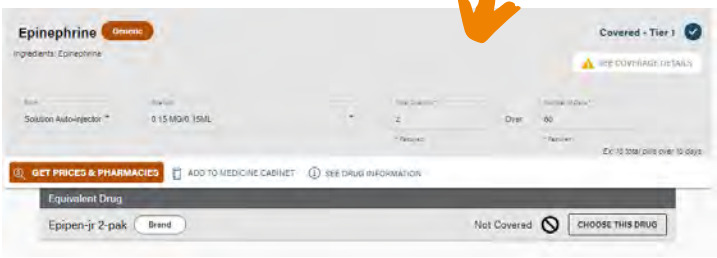
*Cost and Mail Order can vary depending on your specific Pharmacy contract*

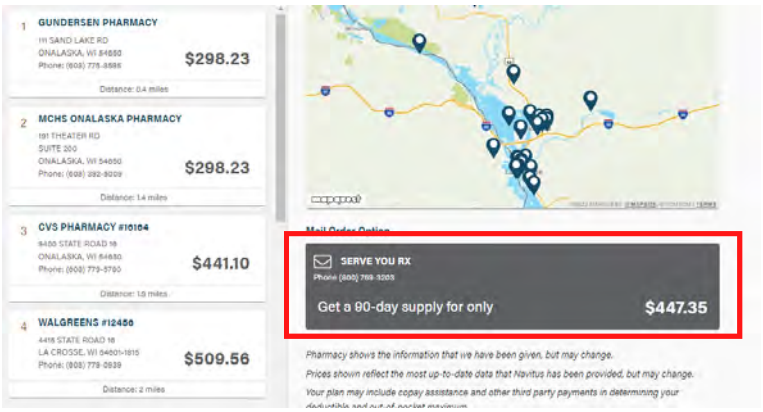
NAVITUS
PHARMACY BENEFITS REINVENTED™

## 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:**
2025: $4,300

**Family Maximum:**
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

## 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.

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.

- 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

**Am I eligible to contribute to an HSA**

# DENTAL INSURANCE

## Delta Dental

Gage Marine offers full time employees the opportunity to enroll in a dental plan through Delta Dental. The dental plan is voluntary, meaning the employee pays 100% of the premium cost.

| SERVICES | PPO PROVIDER | PREMIER NETWORK OR OTHER PROVIDER |
|---|---|---|
| Annual Deductible | $25/Individual<br>$75/Family | $50/Individual<br>$150/Family |
| Individual Annual Maximum<br>Per person, per calendar year | $1,000 | $750 |
| Preventative Services | 100% Covered by Delta<br>(Deductible does not apply) | 80% Covered by Delta |
| Basic Services | 80% Covered after Deductible | 50% Covered after Deductible |
| Major Services | 50% Covered after Deductible | 40% Covered after Deductible |

Preventative Services: Cleanings (prophylaxis), fluoride treatments, sealants, evaluation, bitewing x-rays.

Basic Services: Emergency treatment to relieve pain, fillings and simple extractions.

Major Services: Oral Surgery, crowns, bridges, dentures, implants, repairs and adjustments.

**This plan includes a CheckUp Plus Provision:** CheckUp Plus promotes regular visits to the dentist for exams and cleanings, which can improve your oral health and overall health. CheckUp Plus lets you obtain Diagnostic and Preventative services, including exams, x-rays, regular cleanings and other related treatments without the cost of those services applying to your Individual Annual Maximum.

Delta Dental offers two networks; PPO and Premier. Both save you money! PPO providers offer the lowest agreed upon fees. Premier providers also agree to discounts, just not as deep as PPO. But the Premier network is much broader. Seeing either a PPO or Premier provider will ensure treatments are guaranteed and no balance billing can occur. The only time balance billing will occur is for seeking treatment from an **Out-of-Network Provider** that chooses not to contract with Delta, meaning they are not willing to offer discounted services. 9 out of 10 dentists contract with Delta Dental.

### Your Cost Per Paycheck

| Employee Only | Employee & Spouse | Employee & Child(ren) | Family |
|---|---|---|---|
| $14.37 | $28.74 | $25.95 | $43.50 |

FIND A DENTIST

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

**Or scan the QR Code:**

# VISION INSURANCE

## Delta Vision/EyeMed

Gage Marine provides the opportunity for full time employees to enroll in Vision coverage through Delta Vision.

| COVERED BENEFITS | IN-NETWORK (Insight Network) | NON-NETWORK REIMBURSEMENT |
|---|---|---|
| Vision Exam | $20 Copay | $35 |
| Retinal Imaging | Member pays up to $39 | Not Covered |
| Lenses (Glass or Plastic)<br>Single Vision/Bifocal/Trifocal | $20 Copay<br>See Benefit Summary for additional lens options | $25/$40/$55 |
| Frames | $150 Allowance<br>(20% discount on remaining balance) | $75 |
| Contact Lens Fit & Follow Up:<br>• Standard<br>• Premium | • No Cost<br>• 10% Discount off retail, plus $55 | $40 |
| Contact Lenses:<br>• Conventional<br>• Disposable | • $150 Allowance (15% off balance)<br>• $150 Allowance | $120 |
| Laser Vision Correction<br>Lasik or PRK | 15% off retail price OR<br>5% off promotional price | Not Covered |
| Frequency of Services<br>Based on Calendar Year | Every 12 months: Exam and Lenses OR Contacts<br>Every 12 months: Frames | |

Additional In-Network Discounts: 40% off a second purchase of eyeglasses after benefit has been exhausted, including prescription sunglasses. 15% off second purchase of conventional contact lenses after benefit has been exhausted. Your vision benefits can also be used at glasses.com, lenscrafters.com, targetoptical.com, rayban.com and contactsdirect.com. See full benefit summary for additional benefits offered.

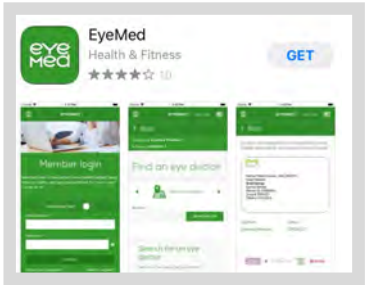
### Your Cost Per Paycheck

| Employee Only | Employee & Spouse | Employee & Child(ren) | Family |
|---|---|---|---|
| $2.90 | $5.79 | $5.91 | $8.81 |

FIND A PROVIDER

Website: www.deltadentalwi.com
**Network: "Insight" Network**
Eye Med Customer Service: 1-844-848-7090
Mobile App: EyeMedMembers

**Or scan the QR Code to find a provider!**



# Basic Term Life and AD&D

## Humana

Gage Marine offers full time employees, Spouse, and Dependent Children a Basic Term Life and Accidental Death and Dismemberment benefit at no cost.

## The Benefit

**Benefit Amount: $25,000**

**Spouse Benefit: $10,000**
**Child Benefit: $2,500**

## Features

**Living Care/Accelerated Death Benefit:**

If you are terminally ill, you may be able to receive a portion of your Life coverage benefit as a lump sum.

**Additional Value Adds:**

- Waiver of Premium
- Conversion Options

THE Insurance CENTER

# Your Service Team

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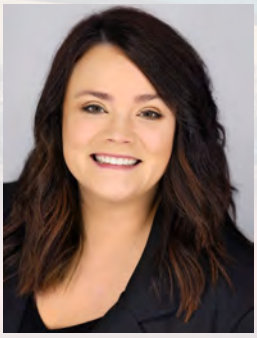

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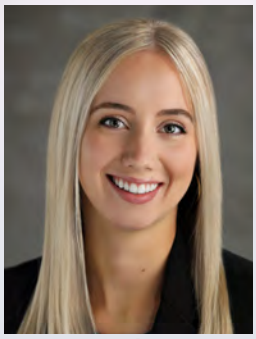

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701 Sand Lake Road
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# 2025 Government Notices

## 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.

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## 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.

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## 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).

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## 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

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## 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.

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**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.

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 Human Resources.


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