

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?

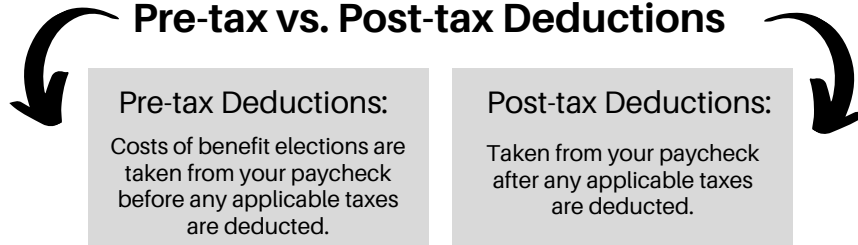
Unless you experience a HIPAA Special Enrollment event, you cannot make changes to the benefits you elect until the next open enrollment period. A Special Enrollment event would include: A loss of eligibility for other health coverage, termination of eligibility for Medicaid or a state Children's Health 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



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 \$2,000 Family	\$3,000 Individual \$6,000 Family
COINSURANCE	80% Gage Marine / 20% Employee	60% Gage Marine/ 40% Employee
MAXIMUM OUT-OF-POCKET (Medical & Rx Combined)	\$4,000 Individual \$8,000 Family	\$12,000 Individual \$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 Retail = 30 day supply Mail Order = 90 day supply	Tier 1: \$10 Copay (\$25 Mail Order) Tier 2: \$35 Copay (\$97.50 Mail Order) Tier 3: \$60 Copay (\$150 Mail Order) 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 earnings into an HSA account.

COVERAGE	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE *(Embedded)	\$3,300 Individual \$6,600 Family	\$6,600 Individual \$13,200 Family
COINSURANCE	100%	60% Gage Marine / 40% Employee
MAXIMUM OUT-OF-POCKET (Medical & Rx Combined)	\$3,300 Individual \$6,600 Family	\$8,000 Individual \$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% <i>Includes \$0 Preventative Drug List</i>	

*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



Our Services

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

No Cost to ALL Employees!
Offered to Spouses and Dependents of those only on the health plan.

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/Trilogy Networks
www.The-Alliance.org

National Wrap Network:



(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 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

AllegianceSM
by Cigna Healthcare

Medical Claims Processor

Please reach out to Allegiance for:

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

1-855-999-7781

www.askallegiance.com



Alithias Care Advocacy






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



How To Research Healthcare Cost & Quality

...And Possibly Get A Cash Incentive!

Call an Alithias Care Advocacy for:

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



Step 1

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



Step 2

askme@careadvocacycenter.com

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 3

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 4

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.



Step 5

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:				
• Smart Infusion	\$750	\$6,500	>\$13,000	
• OSMS Green Bay				
• GI Associates and other Centers of Excellence				
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			
Upper GI (endoscopy with or w/o biopsy)	\$350	\$1,500	>\$10,000	
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 Althias Procedure Incentive Offerings

Procedures	Incentive Amount Paid to Member when using Althias 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.

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.

Cost Per Visit

\$40 HSA Plan
\$0 Copay Plan

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



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.



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



Patient Care Coordination is Multi-Directional

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

- Direct Member outreach
- HR-identified need
- Claims data mining

COVERING A SPECTRUM OF NEEDS WITH COORDINATION

Long Term Clinical Care
Mental Wellness
Mental Health
Mental Illness

- High severity case
- Need beyond visit limit
- Rare Specialty needed
- Need for larger team

Path to

Treatment that provides relief of symptoms that are severe and life-threatening

- PTSD
- OCD
- Borderline Personality Disorder
- Narcissistic Personality Disorder
- Suicide Attempts
- Bipolar Disorder
- Addiction
- Complex Psychopharmacology
- Eating Disorders
- Children & Adolescents ADHD
- Post-Partum Depression
- Psychedelic Medicine
- Interventional Psychiatry
- Dissociative Disorders

- Member calls seeking BH
- Co-occurring conditions
- Claims data mining

- Case Management referral
- Proactive outreach
- Co-occurring conditions
- Member calls
- Claims data mining

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



<https://wire.health>

Call
Care Navigators
855-270-2850

Text
Wire Health
414-626-0120

Scan
our QR
Code

Mayo Clinic Complex Care Program

Mayo Clinic Complex Care Program



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.

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

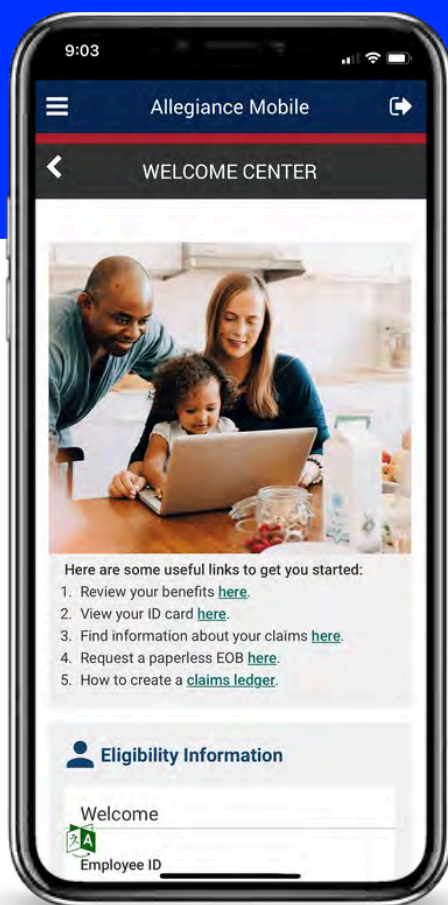
For more information, questions, or to enroll by phone, call the Allegiance Care Management Nurse at 1-877-792-7827 ext. 1.

Allegiance Mobile App

AllegianceSM
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



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 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.

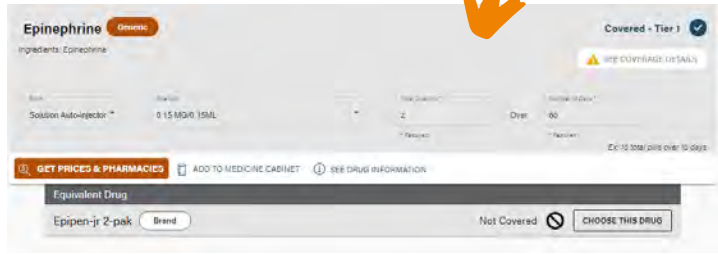
Cost and Mail Order can vary depending on your specific Pharmacy contract



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:

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



Have Questions About Your Pharmacy Benefits?

Answers Are Just a Click Away!

Information about your pharmacy benefit and tools to help you get your prescriptions are available at your fingertips. Visit Navitus' secure member portal at www.navitus.com or log onto your plan's website to access your:

Prescription Benefit Information

Copay Information

Medication History

And try convenient tools including:

Pharmacy Search

Drug Search

Drug Side Effect and Interaction Search

1	GUNDERSEN PHARMACY 111 SAND LAKE RD ONALASKA, WI 54880 Phone: (800) 778-8888	\$298.23
Distance: 0.4 miles		
2	MCHS ONALASKA PHARMACY 181 THEATER RD SUITE 200 ONALASKA, WI 54880 Phone: (800) 778-8888	\$298.23
Distance: 1.4 miles		
3	CVS PHARMACY #10104 8400 STATE ROAD 18 ONALASKA, WI 54880 Phone: (800) 778-8888	\$441.10
Distance: 1.0 miles		
4	WALGREENS #12450 4418 STATE ROAD 18 LA CROSSE, WI 54601-1815 Phone: (800) 778-8888	\$509.56
Distance: 2 miles		

Mail Order Option

SERVE YOU RX
Phone: (800) 788-5205

Get a 90-day supply for only **\$447.35**

Pharmacy shows the information that we have been given, but may change. Prices shown reflect the most up-to-date data that Navitus has been provided, but may change. Your plan may include copay assistance and other third party payments in determining your deductible and out-of-pocket maximum.

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



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 \$75/Family	\$50/Individual \$150/Family
Individual Annual Maximum <small>Per person, per calendar year</small>	\$1,000	\$750
Preventative Services	100% Covered by Delta <small>(Deductible does not apply)</small>	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 \$14.37	Employee & Spouse \$28.74	Employee & Child(ren) \$25.95	Family \$43.50
--------------------------	------------------------------	----------------------------------	-------------------



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) Single Vision/Bifocal/Trifocal	\$20 Copay See Benefit Summary for additional lens options	\$25/\$40/\$55
Frames	\$150 Allowance (20% discount on remaining balance)	\$75
Contact Lens Fit & Follow Up: • Standard • Premium	• No Cost • 10% Discount off retail, plus \$55	\$40
Contact Lenses: • Conventional • Disposable	• \$150 Allowance (15% off balance) • \$150 Allowance	\$120
Laser Vision Correction Lasik or PRK	15% off retail price OR 5% off promotional price	Not Covered
Frequency of Services Based on Calendar Year	Every 12 months: Exam and Lenses <u>OR</u> Contacts 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

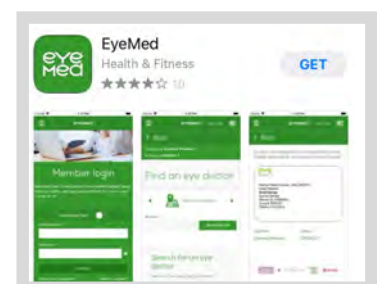
Employee Only \$2.90	Employee & Spouse \$5.79	Employee & Child(ren) \$5.91	Family \$8.81
--------------------------------	--	--	-------------------------



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



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



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



Laura Grana
Account Support Rep
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



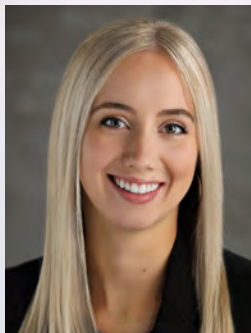
Kim Beckman
Client Success Specialist II
P: 800.944.1367 ext. 30235
F: 608.783.6431
E: kbeckman@ticinsurance.com



Heather Gerken
Client Success Specialist
P: 800.944.1367 ext. 30123
F: 608.783.6431
E: hgerken@ticinsurance.com



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



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



Patsy LaBarbara
Account Support Rep
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

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 \(iowa.gov\)](http://Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)) HIPP Phone: 1-888-346-9562

WISCONSIN – Medicaid and CHIP Website: <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](https://www.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](https://www.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 balance billed for these post-stabilization services.

Certain Services at an In-Network Hospital or Ambulatory Surgical Center

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

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

You're never 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.

Gage

