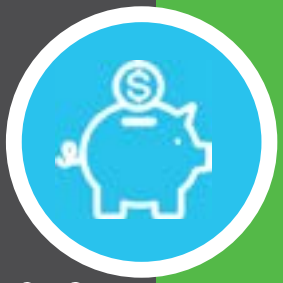
EMPLOYEE BENEFIT GUIDE

2024 -2025

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HUMAN RESOURCES

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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 102-103 for more details.

Excellence Through People

Goals:

Exceptional Service at the Best Price

Enjoyable & Stimulating Work Environment
from which Personal and Professional Growth Can Occur

Bring Our Values to Life

Continuous Improvement
Creativity and Innovation
Customer Driven
Data Driven
Diversity, Equity, and Inclusion
Employee Involvement
Excellence
Fiscal Stewardship
Honesty and Integrity
Leadership
Positive Attitude
Respect One Another
Safety and Wellness
Teamwork

Create the Culture

Model the Way
Inspire a Shared Vision
Challenge the Process
Enable Others to Act
Encourage the Heart

Total City Perspective

Routinely use all resources throughout the organization to provide exceptional customer service

Three types of Total City Perspective
Short duration, spontaneous, one-time need
Coordinated "surge" to address short-term, recurring needs
Strategic changes in providing on-going services

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BENEFITS OVERVIEW

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OVERVIEW & ELIGIBILITY

At City of Ames, we value our people. Our goal is to offer a rewards package that enhances you and your family's health and lifestyle. We also recognize our employees and their families each have unique needs, so we offer options in benefits so that you can choose what you need to have health and security each day.

OVERVIEW

City of Ames is proud to offer a comprehensive benefits package to eligible regular full and part time employees who work at least 20 hours per week. Benefit costs and accruals are pro-rated for employees who work 20-39 hours per week. The complete benefits package is briefly summarized in this booklet. You will receive plan booklets, which give you more detailed information about each of these programs.

You share the costs of some benefits and City of Ames provides other benefits at no cost to you. In addition, there are voluntary benefits with reasonable group rates that you can purchase through payroll deductions.

GROUP BENEFIT PLANS OFFERED

- Medical & Pharmacy
- Flexible Spending Account (FSA)
- Dental
- Vision
- Life Insurance
- Accidental Death & Dismemberment (AD&D) Insurance
- Voluntary Life and AD&D
- Long-Term Disability

Benefits may be added or enhanced during the plan year.

RETIREMENT PLANS OFFERED (TITLE)

*IPERS or Utility Retirement
*MFPRSI (Fire and Police Only)
*Deferred Compensation (457 plan)

RETIREMENT ELIGIBILITY (TITLE)

Employee must be benefits eligible to enroll in Utility, MFPRSI and Deferred Compensation plans. IPERS depends on length of time and hours worked (see page 79 for further details).

ELIGIBILITY

You and your dependents are eligible for City of Ames benefits on the first of the month following 30 days of employment.

Eligible dependents are your spouse, children under age 26, disabled dependents of any age, or children age 26 or older who are unmarried full-time students and continuing coverage under this plan.

Elections made now will remain until the next open enrollment unless you or your family members experience a qualifying event. If you experience a qualifying event, you must contact HR within 45 days.

TERMINATION OF BENEFITS

There can be a number of reasons for any benefit eligible employee to have their benefits terminated. Here is a list of examples:

1. The employee is no longer in an eligible employment status.
2. The employee's employment has been terminated.
3. The employee drops coverage during a qualifying event or at open enrollment.
4. The employee is retiring from the organization and is either already age 65 or will be turning 65 the immediate month after retirement.

Employees can also eliminate dependents voluntarily for qualifying events such as:

1. Marriage, divorce, birth, or death
2. Due to a court order outside of a divorce
3. When a dependent becomes ineligible due to age, student status, and or disability status
4. Any other mandated qualifying event has occurred

EMPLOYEE HR EXTRANET

In our efforts to continuously improve and support City of Ames employees with benefit communications, the Human Resources department provides everyone with an internal website called the HR ExtraNET. The HR ExtraNET is available through all City computers, your home computer with internet access and through any mobile device with an internet browser.

(http://extranet.cityofames.org/myhr/)

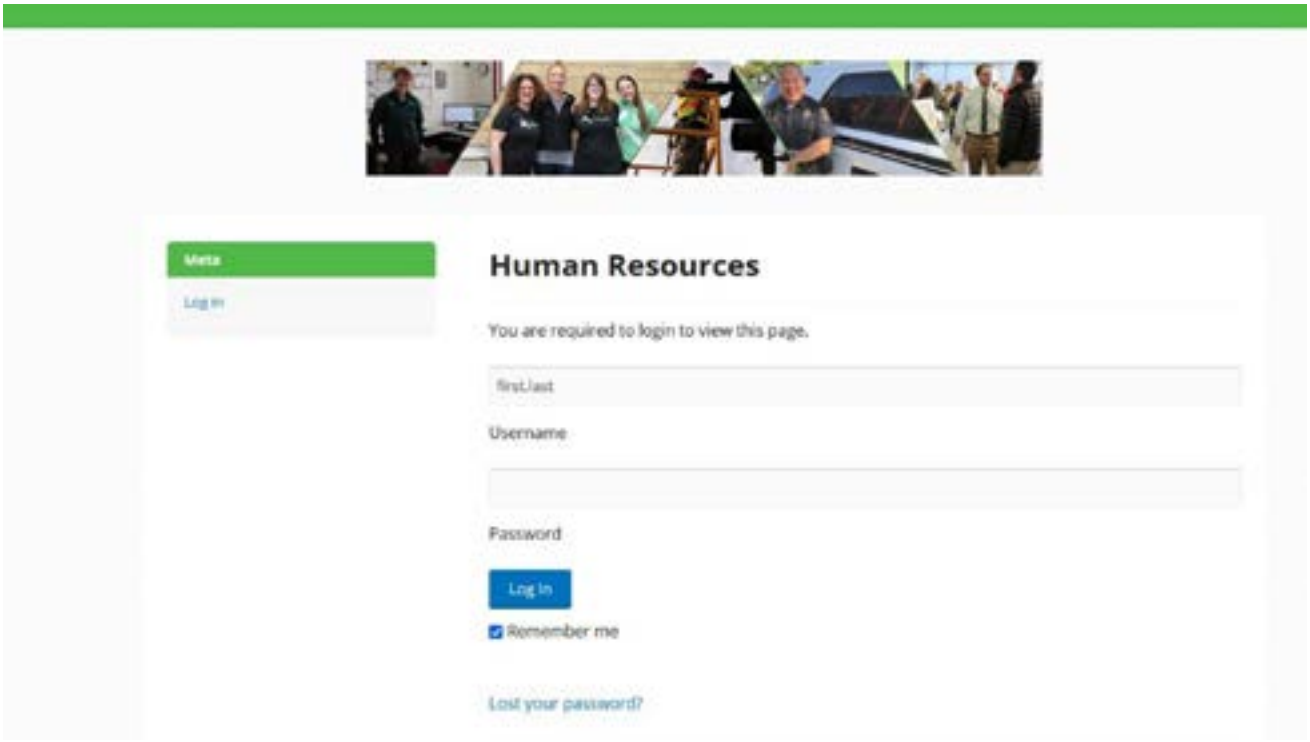
You may also access this site from the City's main website (https://www.cityofames.org) under Human Resources department page. The HR ExtraNET link is on the left-hand side of this page.

SIGNING INTO THE HR EXTRANET

If you are an employee provided with a City computer login, use your username (first name.last name) provided to you by our IT Department and use the same password you use to access your City email account. ***Contact the IT Department if you have difficulty remembering this information.***

If you are a Library employee, here is your ExtraNet information:
- Username: extranet_library
- Password: Welcome123

If you are an employee with CyRide employee without a City email address, here is your ExtraNet information:
- Username: ext_cyride@cityofames.org
- Password: Welcome123!



The HR ExtraNET is where you can find everything HR: Benefit info, forms, and documents, open enrollment communications; Employee Handbook and Policy Library; FMLA information; Health Promotion Program, Employee Assistance Program; Workers Compensation information; Employee Development Center, and more! Check it out and get familiar with it, as most questions can be answered here.

YOU WILL ALSO FIND LINKS TO OFFICE OWA (EMAIL), THE CITY WEBSITE, AND THE PAYROLL PORTAL.

WHAT'S NEW

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WHAT'S NEW AND IMPORTANT FOR JULY 1, 2024?

Premium changes for medical and vision for FY 24-25. (See page 88 under Employee Contributions for Benefits.)

- HMO medical plan members will no longer have PCP names on cards and will not receive a card per each member on your plan.
- Chiropractic visits no longer have a limit per coverage year on any of our medical plans.
- We are offering a choice in Vision plans. One is a base plan with lowered premium and updated network of providers, the other offers the One and Sun program which provides each covered adult member with a free pair of sunglasses with an annual exam.
- For Basic Child(ren) Life Insurance, you will not be required to provide an "evidence of insurability" form for your newly added dependent(s).
- When you buy one pair of glasses under a Vision plan, each member can receive another pair at 40% off.
- If you enroll in a Delta Dental and/or Vision plan, you can participate in the Hearing Benefit Discount.
- The new pharmacy benefit manager for our prescription plan is CarelonRX. New cards were sent out to existing members on January 1, 2024. If you newly enroll during FY 24-25, you will get a separate card from Wellmark per member on your medical plan.
- GeoBlue - Travel Insurance available, see page 18 for details.
- For Diabetes and Pre-Diabetes education courses, there will be an applicable co-insurance or co-pay to each service provided as a claim, depending on the plan you are enrolled and where you receive the service. Classic Blue may require you to meet your individual deductible first before applying the co-insurance.

MEDICAL BENEFITS

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MEDICAL BENEFITS

Administered by Wellmark Blue Cross/Blue Shield

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

Certain preventive care, as defined by the PPACA, will be covered at $0 member cost when received in-network under all three medical plans. For a complete list of preventive services covered at $0 member cost, visit HealthCare.gov.

City of Ames offers you a choice of a Preferred Provider Organization (PPO) or a Health Maintenance Organization (HMO) medical plan. With the PPO, you may select where you receive your medical services. If you use in-network providers, your costs will be less. With the HMO, you must select a primary care physician (PCP). Women may select an additional Woman's Principal Healthcare Provider (WPHCP) with a referral arrangement with their PCP. With the HMO, all care must be provided or coordinated by your PCP, WPHCP or medical group.

	COA BLUE ADVANTAGE HMO	COA BLUE ALLIANCE SELECT PPO	COA CLASSIC BLUE (CLOSED PLAN)
	In-Network HMO	In-Network PPO	In-Network PPO
Lifetime Benefit Maximum	$0	$0	$0
Annual Deductible	$0	$100 Single $100 Single	$200 Family $200 Family
Annual Out-of-Pocket Maximum	$1,000 Single $2,000 Family	$1,000 Single $2,000 Family	$1,000 Single $2,000 Family
Coinsurance/Copay	$10 copay	10% coinsurance	10% coinsurance
DOCTOR'S OFFICE			
Primary Care or Specialist Office Visit	$10 copay	10% coinsurance	10% coinsurance
Preventive Care (routine exams, well child care, mammograms, etc.)	$0	$0	$0
Massage Therapy (limit 12 visits/yr)	$10	10%	Not covered
Acupuncture (limit 12 visits/yr)	$10	10%	Not covered
HOSPITAL SERVICES			
Emergency Room	$50 copay	10% coinsurance after deductible	10% coinsurance after deductible
Inpatient	$100 copay; then 10% coinsurance	10% coinsurance after deductible	10% coinsurance after deductible
Outpatient Surgery	10% coinsurance	10% coinsurance after deductible	10% coinsurance after deductible
MENTAL HEALTH, BEHAVIORAL HEALTH, AND SUBSTANCE ABUSE			
Outpatient Services	$0	10% coinsurance	10% coinsurance
Inpatient Services Practitioner	$0	10% coinsurance	10% coinsurance
Facility	10% coinsurance	10% coinsurance	10% coinsurance
THROUGH CARELONRX			
Tier 1	$5 copay	$5 copay	$5 copay
Tier2	$20 copay	$20 copay	$20 copay
Tier 3	$35 copay	$35 copay	$35 copay
Tier 4	$85 copay	$85 copay	$85 copay
Specialty Drugs	Same as cost-share above depending on drug category	Same as cost-share above depending on drug category	Same as cost-share above depending on drug category

*If you wish to review further details on coverage for each plan, please see the summary of Benefits and Coverage (SBC) or Summary Plan Description (SPD)

MEDICAL BENEFITS

The Importance of your annual preventive care exam

Annual preventive exams are covered at 100% under all plan options. Haven't seen your doctor for your annual preventive exams in awhile? Here are fives reasons to schedule them now.

PREVENT HEALTH PROBLEMS

Annual physicals allow your doctor to review any changes that have occurred since your last visit.

BUILD A RELATIONSHIP WITH YOUR DOCTOR

The more comfortable you are with your doctor, the more likely you are to see him or her when you don't feel right; to be honest; and to follow his/her advice.

ESTABLISH BASELINES

Getting a routine physical will help establish baselines for your weight, blood pressure and cholesterol, which can help identify future progression or regression.

UPDATE VACCINATIONS

Staying up-to-date on your vaccinations (e.g. your flu and tetanus shots) is an important way to prevent illness and its consequences such as missed work.

REVIEW AND RENEW MEDICATION PRESCRIPTIONS

Reviewing your medications with your physician, including over-the-counter medications, will ensure you are treating your medical problems the best way possible and with minimal side effects.

MENTAL HEALTH IS PART OF MEDICAL HEALTH

Make sure to address any changes in your mental well being by utilizing your medical coverage, local resources, and the Employee Assistance Program to the fullest extent.

TO FIND A PHYSICIAN: To locate a primary care physician in-network, use the tool on www.MyWellmark.com or call 800.524.9242

Find care and costs using myWellmark®

Need an in-network **health care provider, facility, or a cost estimate?**
Log in to **myWellmark** for information specific to your health plan benefits.

Here's how to find the information you need using myWellmark

- **Log in or register at myWellmark.com**
- **Click "FIND CARE" from the left-hand side navigation**

1 Find a health care provider

You'll look under the **"SEARCH FOR A PROVIDER"** section. From there, click, **"FIND A PROVIDER"** and search by provider name or specialty. You'll get to view the list of health care providers nearby, who are in-network. You can also view patient reviews, too!

2 Find a facility

You'll look under the **"SEARCH FOR A PROVIDER"** section. From there, click, **"FIND A FACILITY"** to view the list of in-network facilities.

3 Get estimated costs for health care services

On the right-hand side of the page (desktop), you will see **"NEED A COST ESTIMATE?"** You can simply type in the name to find out the estimated cost of common procedures or medications.

Know your cost now so you won't be surprised later.

Rate and review doctors and hospitals

Choosing a health care provider is an important decision. Wellmark makes it easy for you to find helpful information.

See ratings and reviews from other Wellmark members and post your own reviews based on your experiences.

- Review doctors, nurse practitioners, physician assistants and hospitals.
- Use a star-rating system to share your overall rating of your provider's communication skills, availability, facility environment, overall experience and more.
- Keep your reviews confidential. Providers will not know if or how you rated them, but they will be able to view the overall ratings.
- Indicate whether or not you would recommend the provider to others.
- You must be a Wellmark member and verify that you received care from the provider before you can complete a review.

Find a doctor on the go!

Get the care you need, when you need it. The Wellmark mobile app helps you find the nearest doctor, urgent care or hospital within your provider network.

Download the free app today!

Visit myWellmark.com.

Not registered for myWellmark? No problem.

You must be registered to rate a provider or hospital.

Get your Wellmark ID card and get started at myWellmark.com

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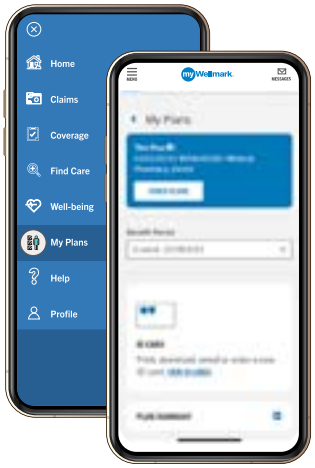
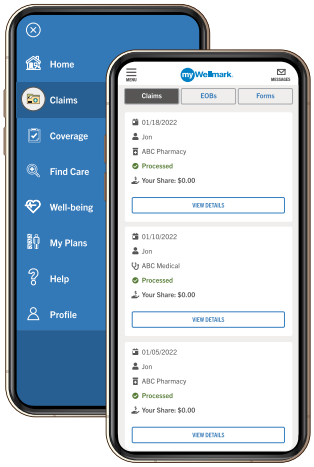
Frequently asked questions about **myWellmark®**

In need of extra help navigating myWellmark? Let us help you find the specific health plan information you're after.



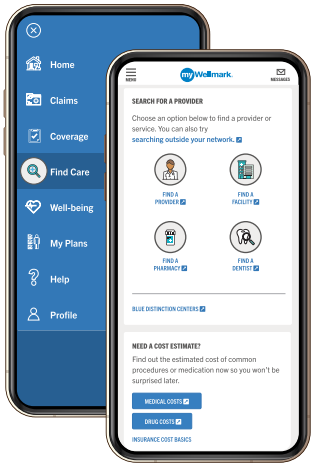
How do I print my health plan ID card?

Navigate to the menu on the left side of the myWellmark homepage. From there, select the **My Plans** tab at the top of the page. Then, follow the **View ID Cards** link. You will be redirected to a page that features a digital copy of your ID card. In the bottom right corner of your digital ID, select the button that says **Print/Save.** From there, you can print a copy of your ID.



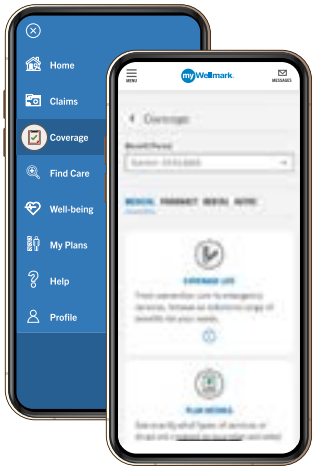
Where do I find my claims information?

Select **Latest Claims,** located on the top of the myWellmark homepage. To view past claims or more claims information, select the **Claims** tab from the menu on the left-hand side of the homepage. Here you'll find information such as all past claims, an Explanation of Benefits (EOB) and various claim forms.



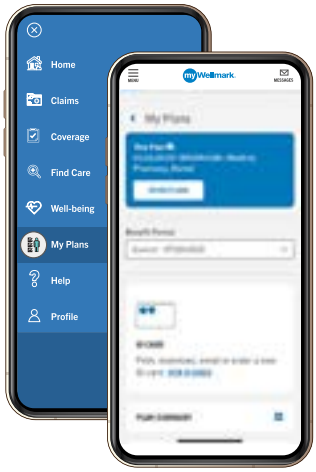
How do I find an in-network primary care provider?

From the menu on the left-hand side of the myWellmark homepage, select the **Find Care** tab. In the section labelled **Search for a Provider,** follow the **Find a Provider** link. You will be taken to Healthsparq.com. From there, you can sort health care providers by name and specialty—including primary care.



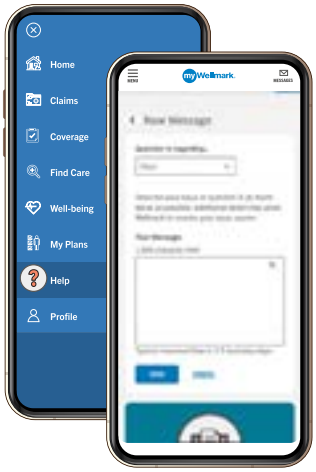
Where do I find how much of my deductible I have met for the year?

On the myWellmark homepage, scroll down to find the box labelled **Your Coverage** and follow the **View Coverage** link. From there, scroll down and select **Deductibles & Maximums.** On this page you can track your plan's deductible and out-of-pocket maximums.



How do I find my benefits information?

Choose the **My Plans** tab from the menu on the left-hand side of the **myWellmark** homepage. From there, you can navigate between and view your different plans. For more detailed information about your benefits, select the **Summary of Benefits & Coverage** (SBC) link.



Still have questions about myWellmark?

Use the **Help** tab at the bottom of the left-hand menu for further assistance. You should receive a reply within two to three business days.

Visit **Wellmark.com/TopQuestions** for answers to more of your coverage questions.

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

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When Wellmark calls SHOULD YOU ANSWER?

The answer is yes.

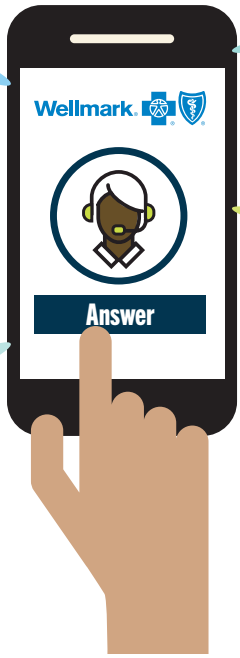
When you see Wellmark on your caller ID, know that a nurse or a Wellmark health support team member may be calling you to help you with your health. Several Wellmark health programs regularly place calls to members.

Health Coaching

This one-on-one support is designed to empower you with the information, tools and help you need to take charge of your health.

Pregnancy Support

Wellmark offers guidance and support to women throughout their pregnancy and postpartum.



Case Management

For severe, complex and chronic conditions (for example, strokes, brain injuries, complications from diabetes and others), Wellmark provides additional nurse coaching and support. We want to help coordinate care for you and overcome barriers you may be facing during your recovery. We will talk through in-home care, meal delivery or other support.

Transition of Care

Wellmark's nurses will contact you for pre and post-discharge follow-up for select hospital admissions to provide education, resources and support. The purpose of these calls is to make sure you are on the path to recovery and have not experienced any new symptoms.

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Wellmark

FEELING BETTER
SHOULD BE EASY.

Visit a doctor on your smartphone, tablet or computer virtually anywhere, any time.

dr. on demand

Getting started is easy.

- Download the Doctor On Demand® app or visit DoctorOnDemand.com.
- Have your Wellmark Blue Cross and Blue Shield member ID card ready.
- Create an account or sign in.

See a doctor in minutes

Getting sick is bad enough without having to get out of bed to see a doctor. With Doctor On Demand, you and your family members can connect face-to-face with a board-certified doctor on your schedule.

Get treatment for:

- Cold and flu
- Bronchitis and sinus infections
- Urinary tract infections
- Sore throats
- Allergies
- Fever
- Headache
- Pink eye
- Skin condition
- Other conditions such as mental health (if covered by your group health plan)[1]

[1] Mental health treatment cost share is subject to group plan coverage. Mental health coverage includes psychiatry services and medication management along with treatment for psychological conditions, emotional issues and chemical dependency. For more information, call Wellmark with the number on the back of your ID card.

QUESTIONS? CALL 800-997-6196.

Callers could experience longer wait times between 10 p.m. and 6 a.m. CST or may be directed to schedule an appointment in some instances.

Your Wellmark medical coverage travels with you across the country or around the world. While you already have coverage that extends your access both inside and outside of the U.S. automatically, you also have the option to purchase additional per-trip coverage depending on your needs.

INSIDE THE U.S.	OUTSIDE THE U.S.
BlueCard® links all Blue Cross and Blue Shield plans across the country, which means your Wellmark plan travels with you.	**Blue Cross Blue Shield Global® Core** (BCBS Global Core) offers you a safety net when traveling abroad.
Included with a Wellmark plan	Included with a Wellmark plan
Access to 96 percent of hospitals and 92 percent of physicians across the U.S.	Access to doctors and hospitals in 190 countries and territories worldwide.
Depending on the type of plan you have, you may only be covered in emergency situations. Visit BCBS.com or call BlueCard Access® at 800-810-2583 before your trip.	Your plan benefits and coverage levels apply in the event you need care during international travel. Depending on your plan, you may only be covered if you have an emergency. Go to BCBSGlobalCore.com for more details.
Your normal plan coverage and cost share will apply.	Usually, you pay for care up front and then submit a claim for reimbursement.
In an emergency, go directly to the nearest hospital.	

Whether you're leaving home for work, school or vacation, be sure to pack your Wellmark ID card, too. It's your ticket to a peace of mind.

Level up on global coverage

Whether you have a once-in-a-lifetime trip or feel like you live out of a suitcase, you can receive convenient, concierge-level service to navigate different health systems across the globe with a **GeoBlue®** plan. Plus, you get exclusive access to:

- Multilingual, 24/7/365 support from customer service and Global Health and Safety experts.
- Elite network of English-speaking doctors.
- Comprehensive coverage includes hospitalization, doctor visits, emergency medical evacuations and prescriptions.
- Direct pay, which means no costly upfront payments for you.
- Easy-to-access mobile app and online tools to keep you informed.

Visit Wellmark.com/GeoBlue or call 800-336-0505 for more information.

Questions? Please contact your authorized Wellmark representative.

Every time she goes for a walk.

Most people are grateful for insurance when something bad happens. But Wellmark Blue Cross and Blue Shield members are grateful for their insurance 365 days of the year. That's because they have Blue365®. Members get exclusive discounts on wellness products and services they use all the time, like fitness trackers, eyeglasses, and athletic shoes.

SIGN UP TODAY AT WELLMARK.COM/BLUE365

Just by being a Wellmark member, you have access to Blue365. When you sign up, you get exclusive discounts for wellness products and services you use every day.

Savings are just a click away

Register for Blue365 at Wellmark.com/Blue365. It's free and you can start saving right away. Browse the discounts and be the first to know about the latest deals to hit Blue365 through a weekly email sent right to your inbox.

Wondering what types of deals are available? Here are just a few ways you can save money while meeting your health and personal goals:

APPAREL AND FOOTWEAR. Save up to 20 percent on Reebok® shoes or 30 percent on Skechers®.

FITNESS. Get access to a network of gyms near you and virtual classes for as low as $19.99 per month. Plus, track your health with discounted wearables from FitBit®, Garmin® and Polar®. If you'd rather work out at home, you can save up to 40 percent on bikes, rowers, and treadmills.

HEARING AND VISION. Save an average of $1,000 on LASIK eye surgery. Or, get discounts on eyeglass and frames, and up to 60 percent off hearing aids.

HOME AND FAMILY. Get up to $2,000 off closing costs through Rocket Mortgage®. Or, make sure your pet's health is covered with 10 percent off pet insurance.

NUTRITION. Eat well for less by saving $200 in food purchases through Jenny Craig® or 50 percent off all Nutrisystem auto-delivery program orders.

TRAVEL. Travel for less with 20 percent off Fairmont Hotels and Resorts.

Visit WELLMARK.COM/BLUE365 for a full list of deals and discounts available to you.

Wellmark members get more

Blue365 isn't the only way you get more for being a Wellmark member. As part of your health plan, you also have access to services like:

- **myWellmark®** — one spot to discover tools and resources for getting the most out of your health care.
- **BeWell 24/7℠** — get connected with a real person who can help you with a variety of health-related concerns. Just call 844-84-BEWELL (239355).
- **Doctor On Demand®** — see a board-certified doctor from virtually anywhere using a smartphone, tablet or computer.

Register for Blue365 today!

Go to Wellmark.com/Blue365. All you need to register is a valid email address and the first three characters of your Wellmark ID number.

Blue365 is a discount program available to members who have medical coverage with Wellmark. This is not insurance.

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you matter.

It's OKAY NOT To Be OKAY

There are higher rates of people within the US who are experiencing anxiety and depression of All ages. Here are some local resources and benefit information to help you and your household members get through these hard times.

CITY RESOURCES

Details of these benefits are found in the Benefit Summary Guide located at the HR Extranet, under Benefits: extranet.cityofames.org/myhr

- Learn more about the services your health insurance provides you and your eligible dependents at MyWellmark.com (Login information found within the Benefit Summary Guide for members.)
- Dr on Demand may also provide other resources to visit psychologists and psychiatrists virtually, if you and your dependents are enrolled in a City Wellmark plan.
- Employee Assistance Program through EFR (800-327-4692) provides all employees and their household members 6 free sessions for each life challenging issue covered under their services.

OTHER LOCAL RESOURCES

- CICS
  Supporting Individuals. Strengthening Communities.

  24-HOUR YOUR LIFE IOWA CRISIS LINE & CICS MOBILE RESPONSE
  Answered by Foundation 2 Crisis Services
  855.581.8111
  Call and request a Mobile Response Team for in-person crisis support services, when applicable.

  Chat support is available anytime at
  www.YourLifeIowa.org or text 855.895.8398.

  A crisis is any stress or pressure that has become too great for you to cope with alone. All contacts & services are FREE & confidential.
  IOWA WARM LINE • 844.775.9276
  If you are not in crisis, but are struggling with a mental health or substance use issue and need someone to talk to, call the 24/7 Iowa Warm Line.
- NAMI Central Iowa
  National Alliance on Mental Illness

  NAMI (National Alliance on Mental Illness)
  NAMI Info Line - (800) 950.NAMI,
  Mon - Fri, 9 am to 9 pm CST
- Suicide Prevention Lifeline
  (800) 273.TALK or (800) SUICIDE
- Veterans Crisis Line
  (800) 273.8255, then press 1

Questions? Contact HR at
hr@cityofames.org or 515.239.5199

CITY OF ames™ HUMAN RESOURCES

PHARMACY BENEFIT MANAGEMENT

CITY OF ames™

carelon Rx

Welcome to your new CarelonRx pharmacy plan

This welcome guide gives you an overview of your pharmacy benefits, so it's easier to manage your prescriptions and your health.

Get more from your benefits

Once your plan is activated, download the CarelonRx app or log in to your account at **carelonrx.com** to:

- Check if a medication is available and find out your coverage, copay, and deductible amounts.
- Find a retail pharmacy near you.
- Access your prescription history.
- Download a convenient digital ID card.
- Order refills and renew home-delivery prescriptions.

Services provided by CarelonRx, Inc.
1043835MUMENCRX BV 08/22

Quicker access to plan information

With CarelonRx digital tools, you can get the most from your benefits. Once your plan is activated, download the CarelonRx app or log in to carelonrx.com.

Save time and money with CarelonRx

Pay less when you use a pharmacy in your plan's network

Your costs are lower when you choose a pharmacy in your plan's network. To search for one, log in to your account, choose **Find a Pharmacy**, and enter your ZIP code or city.

Convenient options for maintenance medications

If you take medications on a regular basis, you can have a 90-day supply delivered to your door. You'll also save money — and shipping is free. To see if your medication is eligible for a 90-day fill, log in to your account, choose **Manage Prescription**, and then select **View, Refill Prescriptions** to see your options.

Support from our specialty pharmacy

If you take certain specialty medications, the CarelonRx Specialty Pharmacy team will contact you about your treatment and filling prescriptions.

Prescription management, on the go

Download the CarelonRx app to access your plan information 24/7:

- Manage refills
- Update account information
- Download a digital ID card
- Chat with a pharmacy member services representative

For more helpful information and answers to common questions, visit **carelonrx.com** and send a secure message or open a live chat session. We're always here for you.

Information on CarelonRx Tiers and How They May Impact Your Prescriptions

Where do I go for finding information on CarelonRx's Drug Formulary List?

Until further notice, CarelonRx has provided us with a special link outside of their webpage to access our Formulary.

Per CarelonRx, the following link is updated MONTHLY and is searchable:

https://client.formularynavigator.com/Search.aspx?siteCode=4807938365

The link below is for a PDF version that is only updated QUARTERLY and is not electronically searchable:

https://fm.formularynavigator.com/FBO/143/City_of_Ames_Complete_Formulary.pdf

I see a tier next to each drug. What do the tiers mean?

The drug list is set up in four tiers or levels. We place drugs in different tiers based on:

- How well they work to improve health.
- If there are over the counter (OTC) options available.
- Their costs compared to other drugs used for the same type of treatment.

How do the tiers affect how much a drug costs?

Typically, the lower the tier, the lower your share of the cost.

Here is a breakdown of the tiers in your plan:

- **Tier 1** drugs have the lowest cost share for you. These are usually generic drugs that offer the best value compared to other drugs that treat the same conditions. Typical copay is $5 per prescription (including a 30-day supply).

- **Tier 2** drugs have a higher cost share for you than Tier 1 drugs. They may include: – Preferred brand-name drugs. They are preferred because of how well they work and their cost compared to other drugs used for the same type of treatment. – Generic drugs that may cost more

because they're newer to the market. Typical copay is $20 per prescription (including a 30-day supply).

• **Tier 3** drugs have a higher cost share than Tier 2. They may include: – Nonpreferred brand-name and generic drugs. They may cost more than drugs in lower tiers that are used to treat the same condition. – Drugs recently approved by the FDA. Typical copay is $35 per prescription (including a 30-day supply).

• **Tier 4** drugs have a higher cost share than Tier 3. They may include: – Brand name drugs that have generic alternatives in a lower tier. When a brand name drug is chosen over an available generic equivalent, you will pay the Tier 4 cost share. Typical copay is $85 per prescription (including a 30-day supply).

FLEXIBLE SPENDING ACCOUNTS (FSAs)

CITY OF
ames™

FLEXIBLE SPENDING ACCOUNT (FSA)

Administered by TASC

Flexible Spending Accounts (FSAs) allow you to set aside pre-tax payroll dollars to pay for eligible medical or dependent care expenses.

WHY FUND AN FSA?

By having pre-tax deductions made from your regular paychecks, you will be able to put money into a flexible spending account (FSA). You pay no federal income or Social Security taxes on your contributions to an FSA. (That's where the savings comes in.)

HEALTHCARE FSA

The money in your healthcare FSA can be used to pay forqualified medical costs, such as;

- Copayments
- Co-insurance
- Prescriptions
- Dental expenses
- Vision expenses

HEALTHCARE FSA FUNDING LIMITS

For 2024, contributions are limited to$100 - $3,200.

Up to $640 of unused funds remaining at the end of 2024 may be carried over into 2025 if you enroll for 2025. Any additional remaining funds will be forfeited.

DEPENDENT CARE FSA

A Dependent Care Flexible Spending Account (DCFSA) can be used to pay for dependent care services, such as preschool, summer day camp, before or after school programs, and child or elder daycare.

With the Dependent Care FSA, you are allowed to set aside$100 to $5,000 to pay for child or elder care expenses on a pre-tax basis.

- Eligible dependents include children younger than the age of 13 and dependents of any age who are incapable of caring for themselves.

Any unused funds remaining at the end of 2024 will be forfeited.

ELIGIBLE EXPENSES IN A DCFSA

Examples of eligible dependent care expenses include:

- In-Home Baby-Sitting Services (not by an individualyou claim as a dependent)
- Care of a Preschool Child by a Licensed Nursery or Day Care Provider
- Before- and After-School Care
- Day Camp
- In-House Dependent Day Care

Enrollment for calendar year 2025 will take place in November 2024.

TASC®

Save up to 30% on eligible expenses

Enroll in a TASC Flexible Spending Account (FSA) so you can use pretax dollars to pay for common, everyday expenses and reduce your taxable income.

Below is a partial list of reimbursable expenses that may be incurred by you, your spouse, or qualified dependents.
NOTE: If you (or your spouse) enroll in an HSA Plan, you may only enroll in a Limited-Purpose Healthcare FSA (LPFSA). The eligible expenses under an LPFSA are limited to Dental and Vision expenses only.

Eligible Medical Expenses

- Acupuncture
- Artificial limbs
- Bandages & dressings
- Birth control, contraceptive devices
- Birthing classes/Lamaze – only the mother's portion (not the coach/spouse) and the class must be only for birthing instruction, not child rearing
- Blood pressure monitor
- Chiropractic therapy/exams/adjustments
- Contact lens and contact lens solutions
- Co-payments
- Crutches (purchased or rented)
- Deductibles & co-insurance
- Diabetic care & supplies
- **Feminine care products** (tampons, pads, etc)
- Eye exams
- Eyeglasses, contacts, or safety glasses (prescription)
- First aid kits & supplies
- Hearing aids & hearing aid batteries
- Heating pad
- Incontinence supplies
- Infertility treatments
- Insulin
- Lactation expenses (breast pumps, etc.)
- Laser eye surgery; LASIK
- Legal sterilization
- Medical supplies to treat an injury or illness
- Mileage to and from doctor appointments
- Optometrist's or ophthalmologist's fees
- Orthopedic inserts
- **Personal Protection Equipment (PPE)** (facial masks, hand santizer, sanitizing wipes)*

**PPE expenses must be used for the purpose of preventing the spread of coronavirus; eligible purchases made on or after 1/1/20 are available for reimbursement.*

- Physical exams
- Physical therapy (as medical treatment)
- Physician's fee and hospital services
- Pregnancy tests
- Prescription drugs and medications
- Psychotherapy, psychiatric and psychological service
- Sales tax on eligible expenses
- Sleep apnea services/products (as prescribed)
- Smoking cessation programs & deterrents (gum, patch)
- Treatment for alcoholism or drug dependency
- Vaccinations & Flu Shots
- X-ray fees

Eligible OTC Medicines and Drugs

Over-the-counter (OTC) medicines and drugs are reimbursable via FSA, HRA, and HSA without a prescription or physician's note if purchased on or after 01/01/2020.
Eligible OTC products include items that are primarily for a medical purpose, and are compliant with federal tax rules under IRS Code Section 213(d).

- Allergy, cough, cold, flu & sinus medications
- Anti-diarrheals, anti-gas medications & digestive aids
- Canker/cold sore relievers & lip care
- Family planning items (contraceptives, pregnancy tests, etc.)
- Foot care (corn/wart medication, antifungal treatments, etc.)
- Hemorrhoid creams & treatments
- Itch relief (calamine lotion, Cortizone cream, etc.)
- Oral care (denture cream, pain reliever, teething gel, etc.)
- Pain relievers - internal/external (Tylenol, Advil, Bengay, etc.)
- Skin care (sunscreen w/SPF15+, acne medication, etc.)
- Sleep aids & stimulants (nasal strips, etc.)
- Stomach & nausea remedies (antacids, Dramamine, etc)
- Wound Treatments/Washes (Hydrogen Peroxide, Iodine)

Continued on next page...

FSA Eligible Expenses

Use your TASC Card® to pay for eligible expenses at the point of purchase instead of paying out-of-pocket and requesting a reimbursement.

Eligible Dental Expenses

- Braces and orthodontic services
- Cleanings
- Crowns
- Deductibles, co-insurance
- Dental implants
- Dentures, adhesives
- Fillings

Eligible Dependent Care Expenses

- Fees for licensed day care or adult care facilities
- Before and after school care programs for dependents under age 13
- Amounts paid for services (including babysitters or nursery school) provided in or outside of your home
- Nanny expenses attributed to dependent care
- Nursery school (preschool) fees
- Summer Day Camp – primary purpose must be custodial care and not educational in nature
- Late pick-up fees
- Does not cover medical costs; use Healthcare FSA for medical expenses incurred by you or your dependents

For more information regarding eligible expenses, please review IRS Publication 502/503 at **irs.gov** or ask your employer for a copy of your Summary Plan Description (SPD).

Eligible Disability Expenses

- Automobile equipment and installation costs for a disabled person in excess of the cost of an ordinary automobile; device for lifting a mobility impaired person into an automobile
- Braille books/magazines in excess of cost of regular editions
- Note-taker for a hearing impaired child in school
- Seeing eye dog (buying, training, and maintaining)
- Special devices, such as a tape recorder or typewriter for a visually impaired person
- Visual alert system in the home or other items such as a special phone required for a hearing impaired person
- Wheelchair or autoette (cost of operating/ maintaining)

Requiring Additional Documentation

The following expenses are eligible only when incurred to treat a diagnosed medical condition. Such expenses require a ***Letter of Medical Necessity*** from your physician, containing the medical necessity of the expense, diagnosed condition, onset of condition, and physician's signature.

- Ear plugs
- Massage treatments
- Nursing services for care of a special medical ailment
- Orthopedic shoes (excess cost of ordinary shoes)
- Oxygen equipment and oxygen
- Support hose (non-compression)
- Varicose vein treatment
- Veneers
- Vitamins & dietary supplements
- Wigs (for mental health condition of individual who loses hair because of a disease)

Questions? Ask your employer or contact your Plan Administrator.
Total Administration Services Corporation • www.tasconline.com • 1-800-422-4661

FX-4248-042021

TASC®

TASC UNIVERSAL BENEFIT ACCOUNT®

PARTICIPANT REFERENCE GUIDE

We hope you will find TASC's Universal Benefit Account to be efficient and valuable. Our participant website is www.tasconline.com and is referred to as TASC throughout this Guide.

This Guide will walk you through your account from the initial Sign Up, Request for Reimbursements, Account Management, to Re-enrollment. Please retain this Guide for future reference. If you have additional questions, sign in to TASC and select Contact Us or call Customer Care toll-free at 800-422-4661.

How to Sign Up

1. To get started, please go to www.tasconline.com. (Chrome is the preferred browser for accessing Universal Benefit Account.) Select the green LOG IN button on the menu bar.

2. From the drop-down menu under Universal Benefit Account Login, select the INDIVIDUAL/EMPLOYEE option. This will take you to the Sign In screen for Universal Benefit Account.

3. The first time you access Universal Benefit Account, you'll need to sign up. This applies to new and existing TASC participants. To sign up, locate the area that says **First time here?** and click on the words **Sign Up**.

4. You will be asked to enter an email address and create a password*. If the email you entered is not recognized, please contact TASC Customer Care for assistance with adding your email address to your profile.

   *Password must be a minimum of eight (8) characters and must contain at least one upper case letter, two (2) lower case letters, and one (1) number. Passwords will expire periodically.

5. After entering an email address and creating a password, click Next. To ensure the safety of your information, you can set up two-factor authentication by entering and verifying your mobile phone number. For the initial signup process, TASC will send a verification code to your email address. Enter the six-digit code and click Verify.

Congratulations! You have successfully signed up for the Universal Benefit Account. You can now manage your benefit accounts online at your convenience.

Overview

With the Universal Benefit Account, TASC created a new customer experience for participants. This includes a simple approach where you can manage your account across multiple channels including web, mobile, and phone.

Today, people move from the internet, to a tablet, to their smart phones. We have designed the Universal Benefit Account to work the way you think. That's how we are providing a seamless and unified experience no matter which channel you're using, with a consistent look and feel and a smart, integrated approach. You can even start an action in one format like the internet and pick it up right where you left off on another device, such as your smart phone.

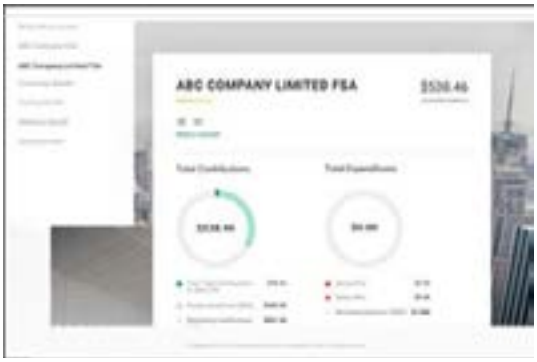
Once you have successfully signed into the web portal, you will be taken to the Overview page. Here you will be able see the details regarding your account(s). All your active accounts will be listed on the left, with the amount of your available balance. Your MyCash balance will be on the upper-right corner of the page. In the middle of this page you will see links to your Reimbursement, Payments, and Recent Transactions. Click on View All under any of these headers to explore the details.

Settings
Under Settings, you can update your Profile Information, such as Notifications, Bank Account Information, Sign In, Security, and Dependents. Just click through to make your selections and update your information. To receive notifications concerning your Account Balances, Reimbursement Requests, and Payments, follow these steps to set up your custom notifications.

- From your Profile page, validate your email address and enter your mobile phone number (a valid email address must be entered to receive text messages).
- Click on Notifications on the left.
- Select the Text, Push, and/or Email Notifications you wish to receive for the following issues (Enrollment, TASC Card, and Reimbursements).

Support/Contact Us
Click on Support for our FAQs and information regarding Customer Care. The Contact Us tab also features two (2) different ways to contact us: telephone or online support request. To learn more about your benefit accounts and how to manage your accounts, visit our New Participant resource page for educational materials and videos.

Benefit Accounts
Under this tab, you can take a deeper dive into your benefit accounts. All your accounts are listed on the left. Click on any account to view details regarding that specific account. You will see your Total Contributions, Total Expenditures, and your MyCash Balance. From this page, you can Pay a Provider or Request a Reimbursement by using the tabs at the bottom of the page.



Transactions
Here is where you find all your transactions. This includes expenditures, reimbursements, contributions, bank transfers, bills and receipts, and donations. Click on any link on the left to view the details. You can search, sort, and attach receipts easily from this page.

New Universal Benefit Account Features

Alerts: Every time you sign into your account online, you may notice you have some alerts. Alerts are our way of calling attention to matters concerning your account that need action. You can access your alerts by clicking on the alert tab at the top of the screen. You will also see alerts posted next to the item needing attention, such as a reimbursement, transaction, or contribution. You can also select how you wish to receive alerts.

Fast Track Service: Everyone knows how frustrating it is to be on hold waiting for customer service. All you need is a quick piece of information, but here you are, stuck on hold. With TASC Priority Queuing, you feel special because your call, transaction, or inquiry gets fast-tracked and you get on with your busy day. There is nothing you need to do to get Priority Queuing; it's all up to your employer. After your employer provides you fast track, you contact TASC with a need or question. TASC's system is smart enough to recognize you and your employer and move your call (or email) into the fast pass line. You get faster resolution, transactions, and service.

IVR Phone System: In addition to TASC online and the TASC Mobile App, TASC also offers an Interactive Voice Response (IVR) phone system. To easily check your account balance, recent transactions, and obtain other account information, call one of the automated phone lines: (608) 241-1900 or (800) 422-4661.

Value-Added Benefits

Identity Theft Protection: TASC Identity Theft Protection provides reimbursement coverage (up to $25,000) to plan participants and their dependent family members for out-of-pocket costs (such as lost wages or financial loss) from a qualifying identity theft incident. TASC provides this benefit to all cardholders at no additional cost. This benefit provides up to $25,000 secondary insurance for loss and includes up to $5,000 coverage for lost wages and dependent care expenses incurred to resolve the issue. TASC's Identity Theft Protection is an insurance policy for your credit and debit cards, including the TASC Card, and for your bank accounts. When an you experience a security breach, all you do is call a special Customer Care number and a trained specialist will assist you with the crisis. This feature is included at no extra cost with the Universal Benefit Account.

Reimbursement Processing & Payment

TASC processes requests for reimbursement daily, and payments are initiated within 48 to 72 hours of receipt of a complete and accurate reimbursement request. All reimbursements are deposited directly into your MyCash account, unless otherwise instructed. You may instead choose to receive a mailed paper check. Paper checks are issued on a limited basis and only upon request. A convenience fee may be applied per check.

TASC Card

The TASC Card is the preferred and most convenient method to access available account funds for all eligible expenses. It automatically pays for and substantiates most eligible expenses at the point-of-purchase, eliminating the need to submit requests for reimbursement and waiting for payment. You will receive a TASC Card within ten (10) days following the completion of your account enrollment. Please watch for it to arrive at your home address along with the Cardholder Agreement in a plain white envelope.

In the meantime, you may submit an online request for reimbursement for expenses incurred prior to receiving your TASC Card. Your TASC Card is good for four (4) years, so hang on to it! Even if you deplete the current year's benefits funds, you'll be able to use the TASC Card again next year when you re-enroll. The TASC Card operates under several separate accounts to serve as both a benefits debit card as well as a cash card.

The TASC Card is issued by MetaBank, Member FDIC, pursuant to license by Mastercard International Incorporated. Mastercard is a registered trademark, and the circles design is a trademark of Mastercard International Incorporated.

Stacked Card: The TASC Card is the most innovative benefit card with features such as MyCash to improve your health, wealth, and well-being from your benefit plan participation. You can use your TASC Card to access funds in all your accounts, even when multiple benefit accounts exist, such as a HSA, HRA, Dependent Care, Parking, and Commuter Transit. The TASC Card allows you to purchase eligible expenses without using your own payment card or submitting receipts for reimbursement. With the Stacked Card feature, not only does your TASC Card know which accounts to access for funds, it also knows in which order the accounts should be accessed when needing to pay for eligible expenses.

Card Benefits

The TASC Card works like a typical debit card but is used as a credit card for all eligible expenses, based on the funds available in your benefit accounts. Rather than paying out-of-pocket and waiting to be reimbursed, the TASC Card allows you to pay for eligible expenses when the service is provided (or when an eligible product is purchased).

When using your TASC Card, the amount of the expense is automatically deducted from your available account balance and paid directly to the authorized provider. All TASC Card transactions and services must occur within the plan year. Remember to save your receipts as you must retain records and documents to validate your TASC Card transactions. In some cases, TASC may require additional documentation regarding a TASC Card transaction.

The TASC Card may only be used at merchants who accept Mastercard and who also have an inventory information approval system (IIAS) in place to identify eligible purchases. At the point of purchase, the IIAS automatically approves the purchase of eligible items and payment is made automatically to the authorized merchant from your benefit account.

Request for Reimbursement

If you pay for an eligible expense out-of-pocket without the TASC Card, submit a request for reimbursement along with substantiation through one of the following methods: TASC mobile app, website, Claim ConneX, mail, or fax a personalized paper request form (download via from your account).

You may request reimbursement any time a qualified expense has been incurred. The service related to the expense needs only to have taken place; it need not be paid before requesting reimbursement. In addition, you may only claim reimbursement for:

- Eligible expenses incurred during the applicable plan year, or subsequent grace period (if applicable);
- Expenses incurred by eligible plan participants; and
- Expenses that have not been previously reimbursed under this or any other benefit plan or claimed as an income tax deduction.

NOTE: It is your responsibility to comply with these guidelines and to avoid submitting duplicate or ineligible claims.

How to request reimbursement:

1. Sign into your account at www.tasconline.com.
2. From the Overview page, select the green box *Request a reimbursement.*
3. Select who incurred the expense.
4. Select the date of the expense.
5. Select the expense date.
6. Enter the expense amount, the merchant, attach the receipt(s), and a description of the expense (optional).
7. Click Next to review your request, and then Submit reimbursement request.
8. Reimbursement is deposited into your MyCash account on your TASC Card.
9. Spend MyCash balance using TASC Card to buy anything!

Receipt Repository: The Receipt Repository enhances and streamlines the online reimbursement request process by allowing you to easily attach receipts and/or bills to an online request for reimbursement of account funds. In the Receipt Repository, you can securely and digitally store and manage receipts and bills needed for reimbursement.

Your receipts and bills can be uploaded by you into your Receipt Repository via the TASC mobile app using your cell phone's camera or can be scanned and/or uploaded from your browser into the Receipt Repository via www.tasconline.com website. Any receipt or bill that you load into the Receipt Repository remains there until you either use it for an online reimbursement request or delete it from the Receipt Repository. Receipts can be uploaded and stored in JPG, JPEG, GIF, PNF, or PDF format and are only viewable by you. Each employee has their own separate Receipt Repository, ensuring information is safe and secure.

Insufficient Funds
If funds in the benefit account are insufficient to cover the entire request, a reimbursement will be issued in the amount of the available balance. The unpaid balance of the request will remain an open item until additional deposits are received, at which time an additional reimbursement payment will be issued.

Pay the Provider: Accessible from the Overview page and the Benefit Accounts page, the Pay the Provider feature offers another simple and fast way to pay for an eligible expense. Click on Pay the Provider, select who incurred the expense, select the date the expense was incurred, and the expense type. Enter the amount, provider or merchant, address (including unit or suite), city, state, and zip code. Attach the bill by clicking on the appropriate box. This will allow you to attach a bill from the bill depository or to browse your computer to locate the appropriate bill. Review and click submit. TASC will send payment from your account directly to your provider.

Direct Deposit – Bank
You can choose to have your reimbursements direct deposited into your bank account. To establish direct deposit of your MyCash funds to a personal bank account, visit the TASC website and click Set Up Direct Deposit. With direct deposit, funds ($25 or more) are forwarded from your MyCash account to your bank within 48 to 72 hours of a completed submission.
NOTE: Remember to verify receipt of deposits before writing checks against expected payments (check with your financial institution for availability of funds). TASC is not responsible if your bank account is assessed insufficient fund fees in anticipation of required deposits to cover requests for reimbursements.

TASC Card Features

MyCash

This TASC Card features a separate cash account known as MyCash where reimbursement payments are deposited (faster than ACH bank deposit) and available via the TASC Card for purchases or ATM withdrawal. All reimbursements are directly deposited into your MyCash account and accessible via the TASC Card. MyCash funds can be spent any way and anywhere Mastercard is accepted. NOTE: Currently MyCash purchases might not be made at CVS Pharmacy, ShopKo, or Walmart.

Access your MyCash funds in any of the following ways:

- Swipe your TASC Card at a merchant that accepts Mastercard;
- Withdraw cash at ATM (with a PIN) using the TASC Card (request a PIN at www.tasconline.com);
- Transfer funds to a personal bank account via the website.

MyCash funds can also be relied upon to cover eligible benefit account expenses if no funds are available in your benefit account (thus avoid embarrassing declines at checkout). It's easy to manage your MyCash reimbursement funds from the TASC website. From www.tasconline.com, go to the overview page to view MyCash activity and card information, save bank account information, and transfer funds to a personal bank account. You can view MyCash activity and balance via the TASC mobile app, too.

NOTE: If you no longer participate in TASC benefits, you may maintain an active TASC Card to access your remaining MyCash funds. Per the participant Terms of Usage, you will be charged a $5 monthly Cash Account Access Service fee, deducted from your cash account each month until all funds are depleted.

TASC Wallet: This convenient organizer offers mobile and web access to the TASC Card. You can request a new card, access your card history, report a lost or stolen card, create a PIN, and request an additional card for a spouse/dependent. You can manage your PIN, report a lost or stolen card, or request a new card. You can even take a picture of a card, such as your insurance card, and store it.

TASC Wallet - Card Holder: Consumers have many types of cards found in their physical wallet. This may be challenging at times to locate specific card information needed. TASC Wallet's Card Holder feature provides participants a highly secure location to easily access information contained on various stored cards. Card information is stored by using the mobile phone's camera to capture the card's image.
Note: Consumers store many types of cards in their physical wallet, such as healthcare insurance, vision plan, and auto insurance.

Lock/Unlock TASC Card: If your TASC Card is lost or stolen, you can quickly disable it with TASC Card Lock online or via the TASC mobile app. When found, simply unlock it and it's ready to use again.

ONE TASC CARD ONE EXPERIENCE

Quickly and easily access your money—anywhere, anytime

The TASC Mastercard® represents the next generation in employee benefit payments! It's unlike any other card in your wallet. The TASC Card has multiple accounts on one card—benefit accounts and MyCash. The TASC Card provides choice and convenience so you can access and use your funds your way.

Use your TASC Card to pay for eligible benefit expenses at the point of purchase, eliminating the need to submit reimbursement requests later.

WHETHER YOU HAVE ONE BENEFIT ACCOUNT OR MULTIPLE, ONE CARD DOES IT ALL.

Free mobile app for Apple and Android devices: search for "TASC app"*

WHAT'S IN YOUR TASC WALLET?

- Card Lock: protect against fraud if you temporarily misplace card
- Card Holder: store important cards online for easy access
- Request a dependent card
- Request a PIN (for ATM use)
- Report a card lost or stolen card

Manage your account online via the TASC mobile app* or website (www.tasconline.com).

*Standard message and data rates may apply.

When your benefits are this smart, easy and connected, you can get back to your priorities: taking care of the people and things you care about most.

A REVOLUTIONARY APPROACH TO EMPLOYEE BENEFITS—BECAUSE AFTER ALL, BENEFITS SHOULD FEEL LIKE BENEFITS.

HOW DOES YOUR TASC CARD WORK?

Your TASC Card is connected to all your employee benefit accounts and provides convenient payment for eligible benefit expenses.

- The card is smart: it knows which account to access based on your purchase and the order the accounts are used.
- Eligible items are automatically approved at authorized merchants and paid from your benefit account.
- Don't worry… your purchases cannot exceed your available account balance.
- Hang on to your card when you deplete this year's funds; you can use the card again next year.
- Use Expense Eligibility Check while you shop.

MyCash: your "stash" and your safety net

On the rare occasion you can't use your TASC Card to pay for an eligible expense, you can submit a reimbursement request online with the mobile app*. Reimbursements are paid to your MyCash** account.

- Use for everyday purchases! Even purchase retail and healthcare items together in one transaction: eligible expenses are paid from your benefit account while other items are paid from MyCash.
- Use MyCash to pay for benefit expenses when your benefit account balance is insufficient.
- Withdraw funds at an ATM (with a PIN)**.
- Transfer to a personal bank account.
- Donate to a favorite charity through your individual giving account.
- MyCash funds are not tied to a plan year and never expire.

SPEND YOUR MYCASH FUNDS YOUR WAY!

2302 INTERNATIONAL LANE, MADISON, WI 53704-3140 | 800-422-4661 | WWW.TASCONLINE.COM | TC-6203-102319

*Standard message and data rates may apply.
**For more information, see your Cardholder Agreement. TASC Card valid only in U.S.

How to Find and Use the TASC Mobile App

With the TASC mobile app you can track and manage all your TASC benefit accounts and access numerous helpful tools, anywhere at anytime. It's full of self-service features and boasts a user rating of over four stars!

Download the TASC App

The TASC mobile app is a free download for your mobile device (Apple or Android). When you're in the Apple App Store or Google Play, search for "TASC" and locate the green app icon (see at right).

Search for "TASC" (green icon)

Sign On to the TASC App

If not already established, you must create an account on Universal Benefit Account® online (uba.tasconline.com/login) with an email and password. You will then use those same login credientials to sign on to the TASC mobile app.

What You Can View (Visibility)

- ✓ Total Contributions (and by account)
- ✓ Total Expenditures (and by account)
- ✓ Transactions
- ✓ Account Details
  - What's Covered (by account)
  - Available Balance
  - Annual Election Amount
  - Employer Contribution
  - Transactions
  - Account Summary

What You Can Do (Functionality)

- ✓ Manage benefit cards in TASC Wallet
- ✓ Receive Alerts

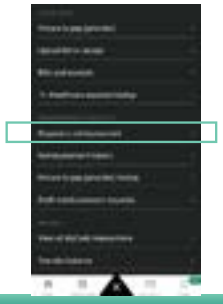
Actions available under the "MORE" button:

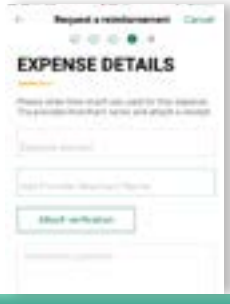
- ✓ Pay a provider with "Picture to Pay"
- ✓ Upload/access substantiation
- ✓ Lookup eligible healthcare expenses
- ✓ Request a Reimbursement (see below)
- ✓ Transfer funds
- ✓ Manage MyCash Account
- ✓ Submit a Support Request (customer care)

How to Request a Reimbursement via Mobile App

Begin by clicking the "More" button and selecting "Request a Reimbursement." Follow the screen prompts to complete the request. Have your substantiation (receipt, EOB, etc.) ready to capture with device camera (refer to your plan specifics to find out if substantiation is required for manual reimbursements).

Important Note for medical expense reimbursements: The reimbursement payment will draw from the healthcare account based on the depletion order set by your employer/plan, thus you are not able to choose which healthcare account to use.





Total Administrative Services Corporation | 2302 International Lane | Madison, WI 53704-3140 | www.tasconline.com | TC-4808-022021

DENTAL BENEFITS

CITY OF
ames™

DENTAL BENEFITS

Administered by Delta Dental

Great dental care can contribute to great overall health. As many as 120 systemic diseases can be visible in your mouth. Research shows that people who have regular dental care have lower healthcare cost burdens—thanks to prevention and early detection.

Employees who enroll in a City of Ames medical plan are eligible to enroll in a City of Ames dental plan.

SERVICES	PLAN 1	PLAN 2
ANNUAL DEDUCTIBLE	$50 PER PERSON; $150 PER FAMILY	$50 PER PERSON; $150 PER FAMILY
ANNUAL BENEFIT MAXIMUM	$1,250	$1,250
PREVENTIVE DENTAL SERVICES	100%	100%
BASIC DENTAL SERVICES	80%	80%
MAJOR DENTAL SERVICES	50%	50%
ORTHODONTIA SERVICES (COVERED TO AGE 19)	NOT COVERED	50% TO $1,500 LIFETIME MAXIMUM
CHECK UP PLUS PREVENTIVE SERVICES (NOT APPLIED TOWARDS ANNUAL MAXIMUM)	INCLUDED	INCLUDED

TO FIND A DENTIST:
To locate a primary care physician in-network, use the tool on www.deltadental.ia.com or call 800.544.0718

DID YOU KNOW?

- More than 120 signs and symptoms of disease can be diagnosed through a routine oral exam.[1]
- For every $1 invested in water fluoridation in the U.S., $38 in dental costs is saved.[2]
- Among adults, more than 164 million work hours are lost each year because of dental problems.[3]

BRUSHING AND FLOSSING BASICS

- **Get Your Mouth in Order.** Flossing first — before you brush — loosens lodged particles, allowing fluoride in toothpaste to reach crevices between the teeth and gums.
- **Dental Care By the Numbers.** For floss — 18 inches is ideal. Toothpaste — a pea-sized dollop will do just fine. As for brushing time — a full two to three minutes, twice daily.
- **Toothbrushes are Like Oil Changes.** Get a new one every three months or sooner if brush bristles are worn.

MAINTAINING A HEALTHY SMILE

Beyond just brushing and flossing, you can help protect your overall oral health a number of ways.

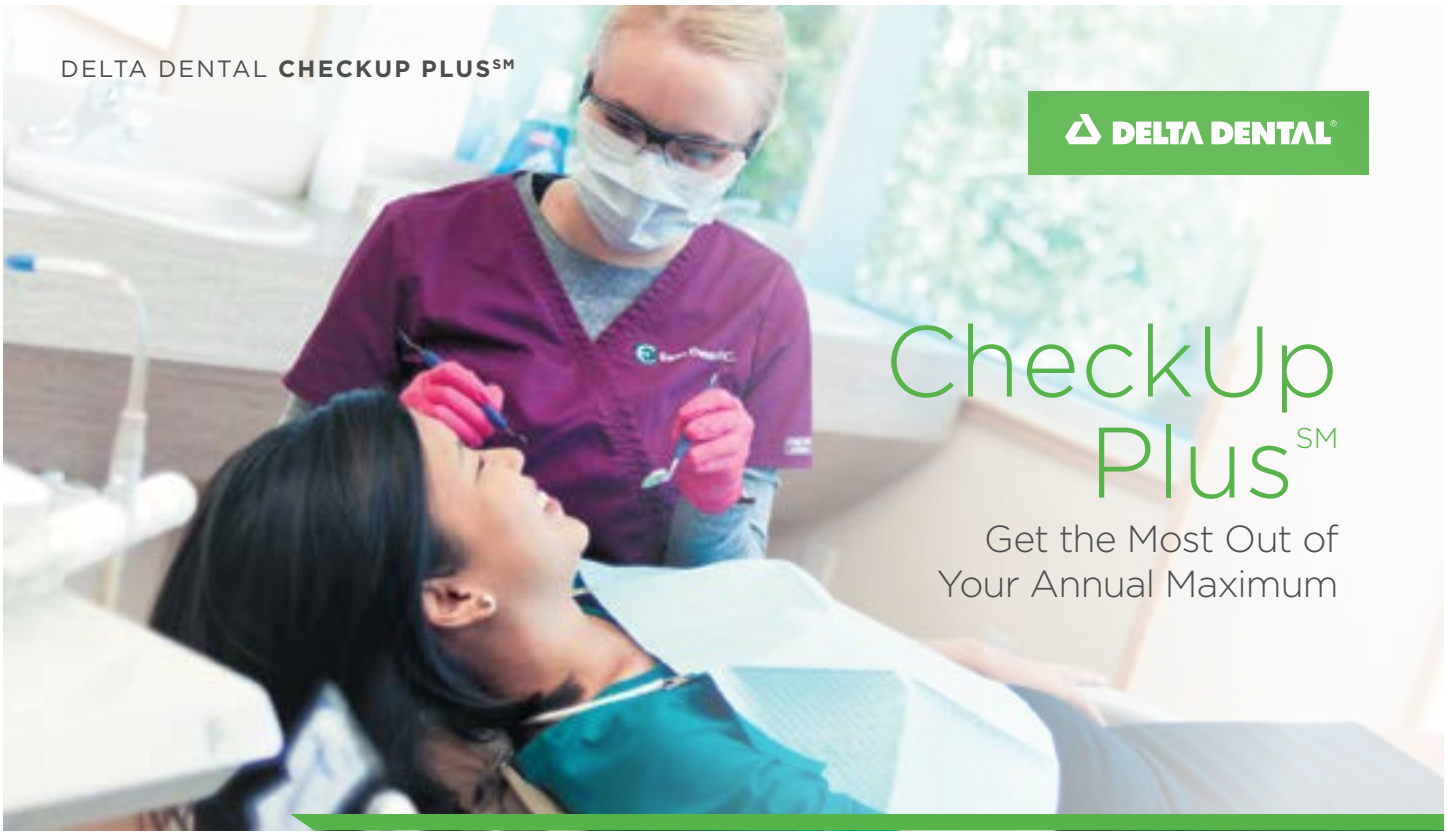
- **Use Fluoride.** Drink fluoridated water and use fluoride toothpaste to protect against dental decay.
- **Avoid Tobacco.** In addition to the general health risks, smokers have seven times the risk of developing gum disease compared to non-smokers.
- **Limit Alcohol Intake.** Heavy use of alcohol poses a risk factor for oral and throat cancers.
- **Eat Wisely.** Avoiding sugars and starches when snacking applies to adults and children. Limit the number of snacks eaten throughout the day.
- **Visit the Dentist Regularly.** Check-ups can detect early signs of oral health problems and can lead to treatments that will prevent further damage and in some cases reverse the problem.
- **Watch Your Sugar.** When choosing a beverage, limit the amount of sugar by diluting sports drinks and juices with water. Also look for sugarfree gum with xylitol.

[1] Steven L. Bricker, Robert P. Langlais and Craig S. Miller, Oral Diagnosis, Oral Medicine and Treatment Planning, 1994. [2] Centers for Disease Control and Prevention, 2016. [3] American Dental Education Association, 2001.

For more oral health tips, visit deltadentalia.com.

Delta Dental of Iowa | 9000 Northpark Drive | Johnston, IA 50131 | 800-544-0718 | deltadentalia.com

1728-F10072 11/2017



NOW THERE ARE NO EXCUSES FOR NOT SEEING A DENTIST

CheckUp Plus encourages you to use preventive services while allowing you to get the most out of your annual benefit maximum. That's because, diagnostic and preventive dental services do not count toward your annual benefit maximum.

CheckUp Plus helps:

- Promote regular visits to the dentist for exams, X-rays and cleanings — which can improve your overall health.
- Save on costs over the long-term because preventive care can help reduce the need for more expensive dental services.

WHAT SERVICES ARE INCLUDED*?

- Examinations
- Routine X-rays
- Cleanings
- Sealants
- Fluoride applications

BENEFITS WITHOUT CHECKUP PLUS

Example assumes two routine checkups (2 exams, X-rays, 2 cleanings), covered at 100% and $1,000 annual maximum.

Delta Dental Pays	Member Pays	Annual Maximum Remaining
$350	$0	$650 ($1,000 minus $350)

BENEFITS WITH CHECKUP PLUS

Example assumes two routine checkups (2 exams, X-rays, 2 cleanings), covered at 100% and $1,000 annual maximum.

Delta Dental Pays	Member Pays	Annual Maximum Remaining
$350	$0	$1,000

Plan benefit and dentist charges vary.

* Benefits may vary, please see your Benefits Certificate for plan details.

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1724-F10062 092017

DELTA DENTAL®

DeltaVision®

YOUR BENEFIT

INFORMATION AT YOUR FINGERTIPS

Get Started Today!

Make the most of your dental and/or vision benefits with Delta Dental of Iowa's online Member Connection. Sign up today at **www.deltadentalia.com** to:

- Print an ID card
- View claim details and status
- Find a provider
- Find eligibility and benefit information
- Access an explanation of benefits (dental only)

To register for Member Connection:

1. Go to **www.deltadentalia.com** and select "New user? Sign up." in the "My Account" box on the right side of the homepage.
2. Complete the online registration.
3. Create a username and password, enter your email, create a challenge question and then click on "Register User."
4. Once your account has been created, be sure to go back to **www.deltadentalia.com** to log-in and view your complete account information.

Helpful tips when registering:

- Enter first and last name for the primary subscriber (exactly as your employer entered it during enrollment; e.g., "Bob" may be "Robert")
- Enter assigned subscriber ID or Social Security number (enter the nine digit number with no dashes or leading zeros)

TO REGISTER FOR MEMBER CONNECTION
Visit **deltadentalia.com**

Connect with Delta Dental of Iowa

At Delta Dental of Iowa, we provide several free oral and vision health resources for our members in a variety of formats.

A Healthy You eNewsletter
deltadentalia.com/newsletter
Sign up to receive relevant dental and vision wellness information in your inbox each month.

B Facebook
facebook.com/deltadentalia
"Like" our Facebook page for upcoming events, photos from events, helpful oral and vision health articles, contests and more!

C Delta Dental Blog
deltadentalia.com/a-healthy-life
Our blog is regularly updated with short articles and tips to help you keep your smile and eyes healthy. You can browse by topic or keyword, and subscribe to receive email updates when new articles have been posted.

D Twitter
twitter.com/deltadentalia
Follow us for regular tweets on oral and vision health care, helpful tips, links to articles about dental and vision care and contests for fans and followers.

E Pinterest
pinterest.com/deltadentalia
Follow our Pinterest board to see the latest tips on improving oral and vision health and view new product information.

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2523-F10198 01/20

DELTA DENTAL®

Delta Dental of Iowa Enhanced Benefits Program

Your dental plan includes Delta Dental of Iowa's Enhanced Benefits Program, which links medical conditions and dental benefits. This benefit offers additional oral health services to members with the following conditions:

Cancer, Chemotherapy and/or Radiation – A common side effect of head and neck radiation is an increase in cavities. The National Institute of Dental and Craniofacial Research recommends fluoride treatment and the use of prescription-strength fluoride toothpaste for those undergoing this treatment.

Diabetes – Studies have shown in cases where diabetes is poorly controlled, patients who receive additional cleanings may see better-controlled glucose levels. Research has also confirmed that diabetes worsens with periodontal disease, and it strongly suggests that severe periodontal disease increases the severity of diabetes.

High-Risk Cardiac Conditions – By maintaining good oral health, individuals may reduce harmful inflammation in the body, which has been shown to reduce the risk of cardiovascular disease. The following conditions are eligible for benefits: a history of infective endocarditis; certain congenital heart defects; individuals with artificial heart valves; heart valve defects caused by acquired conditions; hypertrophic cardiomyopathy; individuals with pulmonary shunts or conduits; and mitral valve prolapse with regurgitation (blood leakage).

Kidney Failure or Dialysis – Dental infections increase the risk of systemic infection in people with kidney disease, and systemic infection increases the risk of serious side effects. Additional cleanings can reduce the buildup of bacteria in the mouth and help lower the risk of bacteria that will enter the bloodstream, create infection and further compromise their health.

Periodontal (Gum) Disease – For enrollees with a history of susceptibility to periodontal diseases or periodontal surgery, periodontal maintenance may need to be conducted at more frequent intervals than the traditional two cleanings per year. The additional cleanings are not only more economical than periodontal surgery, but also help maintain overall health and reduce tooth loss.

Pregnancy – Clinical studies of pregnant women with periodontal disease strongly suggest that more frequent professional teeth cleanings will benefit the health of both the baby and the mother.

Suppressed Immune Systems – With extra cleanings, patients that are HIV positive or have organ failure may reduce the buildup of bacteria in the mouth that may enter the bloodstream, create infection and further compromise their health.

	Cleanings	Fluoride Application*
Cancer-Related Chemotherapy and/or Radiation	4 cleanings per year	Fluoride application
Diabetes	4 cleanings per year	
High-Risk Cardiac Conditions	4 cleanings per year	
Kidney Failure or Dialysis	4 cleanings per year	
Periodontal (Gum) Disease	4 cleanings per year	Fluoride application
Pregnancy	1 additional cleaning	
Suppressed Immune Systems	4 cleanings per year	Fluoride application

* Coverage for services will be at the group-contracted benefit level, with the additional frequency allowance being the only change. There are no age requirements and the patient may be the subscriber, spouse or other covered dependent. Fluoride will only apply if this is a covered benefit under the group's dental plan.

How to Sign Up for the Enhanced Benefits Program

To receive the additional dental benefits, you must enroll in the Enhanced Benefits Program.

To enroll online:

1. Go to Delta Dental of Iowa's member website at **deltadentalia.com** and sign into the Member Connection. (You must be a registered user of the Member Connection to enroll in the Enhanced Benefits Program.)

2. After you have successfully signed in, click on the "My Benefits" tab.

3. Choose the "Enhanced Benefits" tab and click on "Enroll Now."

4. Select the member and the applicable medical condition and click "Submit." You and/or your dependents will be immediately eligible for the Enhanced Benefits Program.

Please note: The periodontal disease health condition indicator will automatically be updated when qualifying nonsurgical or surgical periodontal procedures are processed by Delta Dental of Iowa.

You can also enroll in the Enhanced Benefits Program by asking your dentist to notify Delta Dental of your condition(s) or by calling Delta Dental's Customer Service at 800-544-0718, Monday – Friday, 7:30 a.m. – 5:00 p.m.

For more information regarding your benefits, sign up for the Member Connection on Delta Dental's website at **deltadentalia.com**.

1

2

3

4

DELTA DENTAL

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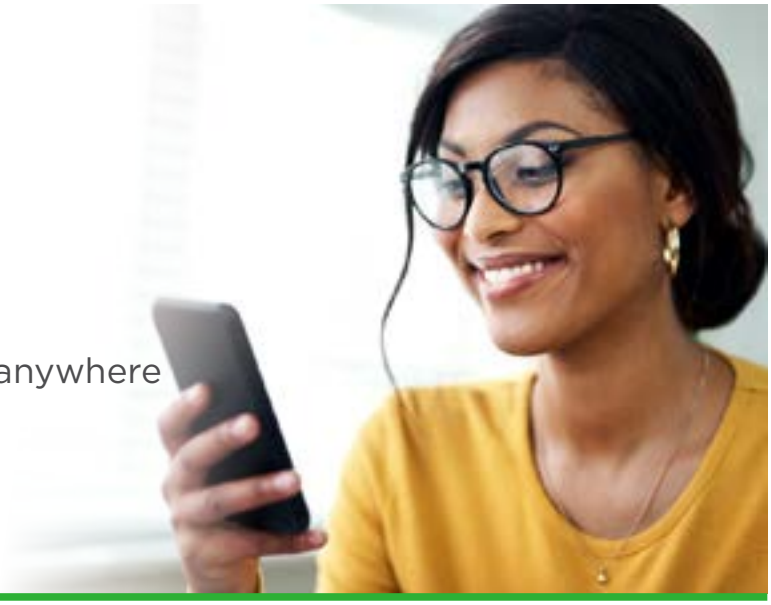
DELTA DENTAL

Delta Dental Mobile App

Manage your oral health anytime, anywhere



Your oral health is important to Delta Dental — and to your overall health! We've designed our mobile app to make it easy for you to make the most of your dental benefits. Maximize your health, wherever you are! Search for a dentist near you, view ID cards and more, right on your mobile device.

Getting started

The Delta Dental Mobile App is optimized for iOS (Apple) and Android devices. To download our app on your device, visit the App Store (Apple) or Google Play (Android) and search for Delta Dental Mobile App. Or, scan the QR code below. You will need an internet connection in order to download and use most features of our free app.

Logging in to view benefits

Delta Dental members can sign in using the username and password they use to sign in to our website. If you haven't registered for an account yet, you can do that within the app. If you've forgotten your username or password, you can also retrieve these via the Delta Dental Mobile App.

SCAN TO DOWNLOAD
DELTA DENTAL MOBILE APP

Delta Dental Mobile App features

Sign in to access the full range of tools and resources

Mobile ID card
No need for a paper card. View and share your ID card from your phone, and easily save it to your device for quick access, including Apple Passbook and Google Wallet.

Find a dentist
It's easy to find a dentist near you. Search and compare dental offices to find one that suits your needs. Save your family's preferred dentists to your account for easy access.

Dental Care Cost Estimator
Find out what to expect with our Dental Care Cost Estimator. Our easy to use tool provides estimated cost ranges on common dental care needs for dentists in your area, now with the option to select your dentist for tailored cost estimates.

Save your preferred dentist for quick access
Save your favorite dentists using the Delta Dental Mobile App for quick access to contact information making it easy to schedule your routine cleaning.

My claims
Look up detailed claims information for your dentist visits over the last 18 months.

My coverage
Review your dental policy coverage details such as deductibles, maximums, and other benefits.

Secure access to your benefits

You must sign in each time you access the secure portion of the mobile app. No personal health information is ever stored on your device. For more details on security, our Privacy Policy can be viewed by clicking the lock icon on the main menu.

deltadental.com

DELTA DENTAL®

Children's Oral Health

Good Habits Start Early

DID YOU KNOW?

- Childhood dental cavities rank as the most common chronic condition among children.
- Children should visit the dentist by age one.
- Childhood cavities are nearly 100% preventable.

Small changes in dental habits can have big effects on a child's dental health. At Delta Dental of Iowa, we realize how important it is to begin promoting good oral health at an early age. That's why we put together this guide especially for you and your children.

RISK FACTORS FOR INFANT CAVITIES

Infants may be at risk for getting cavities if any of the following are true:

- A bottle with milk or juice is used at nap time or before going to sleep.
- Siblings have had dental decay before the age of 5.
- Excessive sweets, juice or sticky foods in diet.
- Inadequate brushing and cleaning routine.
- Insufficient fluoride in water and lack of supplements.
- Chalky white spots on teeth.

FLUORIDE IS IMPORTANT TO YOUR CHILD'S HEALTH

Many communities now have fluoride added to the public water supply to provide residents with the proper amount of fluoride needed to ward off cavities. Talk to your dentist or hygienist to see if your child needs more fluoride. They can prescribe fluoride supplements to help protect your child's teeth against decay.

Facts on Fluoride

- In water it has been proven to reduce cavities by up to 50 percent.
- Fluoride is a mineral that helps developing enamel become strong and resistant to decay.
- Fluoride slows the growth of bacteria.

How to Care for Your Child's Teeth

THE FIRST TOOTH
Ages 0 to 23 months

- Before your baby's first tooth erupts, clean his or her gums with a damp washcloth after feedings. Cleaning your baby's gums will help keep bacteria levels low and maintain a clean home for his or her new teeth.
- Some babies experience sore gums and general discomfort when teething. Signs of teething include crankiness, lack of appetite, excessive drooling, restless behavior, pink or red cheeks, coughing, upset stomach and chewing or sucking on fingers and toys. You can help relieve the pain with teething toys or by giving your baby a cold, wet cloth to suck on.
- Once the first tooth erupts, use a soft toothbrush and water to brush your baby's teeth and gums in soft, gentle circles twice a day, and check for any spots or stains.
- Within six months of getting the first tooth — and no later than the first birthday — your baby should have his or her first dental visit.

BASIC PREVENTIVE CARE
Ages 2 to 6

- Use a smear (grain of rice-sized amount) of fluoridated toothpaste for children up to age 3. After your child's 3rd birthday, a pea-sized amount may be used. Parents should dispense toothpaste for young children and supervise and assist with brushing.
- Help your child brush properly twice daily, until he or she has the motor skills to handle the toothbrush alone.
- Your child's dentist will be able to spot any areas that may require extra attention when brushing. The dentist will also check for orthodontic problems, clean and polish teeth, apply a fluoride treatment and maintain a dental history for your child.

SEALANTS, DIET AND THE TOOTH FAIRY
Ages 7 to 12

- Your child's dentist may suggest that your child get sealants on their permanent molars as soon as the teeth come in — before decay attacks the teeth. The first permanent molars — called "6 year molars" — come in between the ages of 5 and 7. The second permanent molars — "12 year molars" — come in when a child is between 11 and 14 years old.
- Dental sealants are an easy, effective preventive measure. Once applied, they last about 10 years, and will need to be checked periodically for chips and wear.
- As a permanent tooth erupts, it pushes the primary tooth out of the way. Once a primary tooth is loose, have your child wiggle it back and forth or eat hard, crunchy foods to help it along.
- Frequent snacking allows sugars to build up in the mouth, increasing the risk of decay. When your child does snack, offer nutritious options like raw veggies, plain yogurt or fresh fruit. Afterward, encourage your child to drink water to rinse away food particles.
- Avoid sticky foods, such as chewy candy. These foods are not easily washed away by a drink or saliva, so they have high cavity-causing potential.
- Make sure your child is getting the recommended supply of calcium. In addition to building strong bones, calcium helps keep the teeth, gums and jawbones healthy. Milk and other dairy foods are excellent sources of calcium.

For more information on creating a lifetime of good oral health and maintaining a healthy smile, go to deltadentalia.com.

DELTA DENTAL®

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1729-F10072 11/2017

Your orthodontia benefits depend on the dental plan you have through Delta Dental of Iowa. Generally, Delta Dental will pay 50% of the treatment cost, up to a lifetime maximum benefit and a specified age.

HOW BENEFIT PAYMENTS WORK

Orthodontic treatment normally occurs over an extended period of time, so benefit payments are made over the course of treatment. The covered child must have continuous coverage under the dental plan to receive ongoing orthodontic benefit payments. For treatments that are in progress, Delta Dental will only pay for services received after your plan is effective.

Benefit payments are made:

1. When braces are initially placed.
2. Quarterly until treatment is completed or until the lifetime maximum benefit is reached.

Below is an example of what you could expect if you have a child who needs braces.

Total fee charged	$6,000
Treatment length	24 months
Prior months of treatment	18 months
Dental plan lifetime maximum benefit	$1,500
Down payment (25% paid upon placement)	$1,500 ($6,000 x 25%)
Charges for monthly fee	$4,500 ($6,000 - $1,500)
Monthly fee	$187.50 ($4,500/24 months)

The chart below shows how to determine what your plan would pay vs. what you would pay out-of-pocket:

TREATMENT IN PROGRESS		
	Delta Dental of Iowa*	**You**
Down payment	N/A	Would vary based on your previous plan
Monthly fee	$93.50 (50% of $187.50 monthly fee paid quarterly up to $1,250**)	$93.50 (50% of $187.50 monthly fee until the plan maximum is met) $187.50 (for remaining months of treatment)
Ineligible amount	$4,875 (18 months x $187.50 monthly fee + $1,500 down payment)	N/A
Total amount paid	$562.50 ($93.50 x remaining months of treatment)	$562.50
Plan lifetime ortho maximum remaining	$1,437.50	N/A

*You may be subject to a deductible. Please see your benefit summary for plan details.
**Benefit payments may meet plan maximum before treatment is complete.

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1781-F10060 092017

chewsi®

IN PARTNERSHIP WITH

CITY OF Ames

Chewsi is the whole new way to save on dental care

Chewsi connects you with dentists who offer savings on any service — savings you can't get on your own.

Chewsi is easy as 1-2-3

1. Download the Chewsi app and register with code **Ames**
2. Find a Chewsi dentist near you and call to make an appointment
3. Use your smartphone to pay at the dentist and see your savings immediately

Chewsi has you covered.

- **No-cost dental benefit for all employees**— whether you have dental insurance or not. No restrictions, exclusions or limits means no monitoring maximums or remaining benefits for you or your family.
- **Chewsi is ideal if:**
  - You don't have dental insurance
  - You need dental services not covered by your dental plan
  - You like to save on dental care with no monthly or annual fees
- **For all employees:**
  - Full-time
  - Part-time
  - Seasonal

Savings for yourself, a friend or any family member.

ChewsiDental.com **(515) 823-8514**

Big savings. No monthly fees. No hassles.

Finally, there's a simple way to save at the dentist. Chewsi® is the free app that gets you instant savings on your dental care.

With Chewsi, you can save on *any* dental service, any time and you never pay a monthly or annual fee. Ask your dentist how you can use Chewsi to save today.

SAVE UP TO 25% ON:

- Cleanings & exams
- X-rays & fillings
- Implants & crowns
- Whitening & veneers
- Braces & night guards
- And more!

No exclusions. No restrictions. No rules. Just big savings.

NO INSURANCE? NO PROBLEM!

With Chewsi, you're in control of your expenses. Unlike insurance or discount dental plans, Chewsi doesn't charge a monthly and annual subscription fee. **You only pay for the care you need, when you need it.** Your care is strictly between you and your dentist. We never intervene. We just help you save.

"Chewsi was easy, convenient and without question, great savings. It took five minutes to sign up and I saved over $120. That's a good day!"
—Helen P.

Ready to start saving? Download Chewsi today.

VISION BENEFITS

CITY OF
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VISION BENEFITS

Insured by Delta Vision

Regular eye examinations can not only determine your need for corrective eyewear, but also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone.

	BASE PLAN IN-NETWORK MEMBER'S COST	BUY-UP PLAN IN-NETWORK MEMBER'S COST
Eye Exam with dilation and refraction - once per calendar year	$10 copay	$0 copay
Frames - once every 2 calendar years	80% of balance over $150	80% of balance over $150
One & Sun free sunglasses with eye exam - see flyer on page 51	Not Included	$0 Copay
LENSES - ONCE PER CALENDAR YEAR		
Single Vision Lenses	$0 copay	$0 copay
Bifocal Lenses	$0 copay	$0 copay
Trifocal Lenses	$0 copay	$0 copay
Standard Progressive Lens	$75 copay	$75 copay
Premium Progressive Lens Tier 1/Tier 2/Tier 3/Tier 4	$95/$105/$120/80% of charge less $120, plus $75 copay	$95/$105/$120/80% of charge less $120, plus $75 copay
Lenticular	$0 copay	$0 copay
Other Lens Type	80% of charge	80% of charge
LENS OPTIONS		
Standard Polycarbonate	$40 copay	$40 copay
Standard Plastic Scratch Coating	$15 copay	$15 copay
Tint (Solid and Gradient)	$15 copay	$15 copay
UV Treatment	$15 copay	$15 copay
Standard Anti-Reflective Coating	$45 copay	$45 copay
Other Lens Options	80% of charge	80% of charge
CONTACT LENSES - once per calendar year if elected instead of lenses		
Medically Necessary	$0	$0
Disposable Lens	Balance over $150	Balance over $150
Conventional Lens	85% of Balance over $150	85% of Balance over $150
Standard Fit & Follow Up Exam	$0	$0
Premium Fit & Follow Up Exam	$0 copay, 10% off retail, then $55 allowance	$0 copay, 10% off retail, then $55 allowance
LASIK OR PRK VISION CORRECTION	85% of Retail Price or 95% of Promotional Price	85% of Retail Price or 95% of Promotional Price

EVERYONE GETS A 2ND PAIR OF GLASSES AT 40% OFF WHEN THEY ORDER THEIR FIRST PAIR EACH QUALIFYING YEAR.

TO FIND A PROVIDER:
To locate a provider in-network (Insight), use the tool on www.deltadentalia.com/deltavision or call 888.899.3747

DeltaVision®

Your Eyes & Your Health

Why Is Vision Care Important?

Comprehensive vision exams aren't just for those who need glasses or contacts. Exams also make it easier to **find serious eye and general health conditions** like diabetes, high blood pressure, high cholesterol, glaucoma and cataracts sooner.[1]

And because early detection is key for treatment, regular eye examinations can make a big difference. When you consider the fact that the average person is **four times more likely** to get an eye exam than a physical, it's easy to see how important vision care can be.[2]

Did You Know?

- Diabetes is the **#1 cause** of blindness in adults.[3]
- About **2 million** Americans have glaucoma and don't know it.[4]
- **50,000 people** lose their sight each year, even though half of all causes of blindness can be prevented with proper care.[5]
- **24.4 million** U.S. adults over age 40 have cataracts, which can result in double or blurred vision.[6]
- **Over 9 million** adults experience macular degeneration, the leading cause of vision loss among older Americans.[7]
- Almost **80% of employees** say they deal with a vision disturbance at work every day.[8]
- **80% of learning** in a child's first 12 years comes through the eyes. **Up to 25%** of school-age children may have vision problems that can affect learning.[9]

ROUTINE EYE EXAMS

are a **simple, non-invasive tool** that can help identify early signs of certain chronic health conditions.

[1]"Health Problems Eye Exams Can Detect," YourSightMatters.com, March, 2016. [2]U.S. Dept. of Health – National Health Statistics Reports #8; Aug. 6, 2008. [3]www.diabetes.org; American Diabetes Association, Statistics About Diabetes; sourced April 2016 [4]www.glaucoma.org; Glaucoma Facts and Stats; Glaucoma Research Foundation; sourced April 2016. [5]American Academy of Opthalmology. [6]National Eye Institute data, www.nei.nih.gov/eyedata/cataract, 2010. [7]All About Vision, https://www.allaboutvision.com/conditions/amd.htm, August 2018. [8]HR.BLR.com, 2015. [9]Vision Council, February 2012 Parent for Child Report.

FOR MORE VISION CARE TIPS

Visit **deltadentalia.com**

DELTA DENTAL®

2497-F10185 10/2019

DeltaVision®

The Window To Wellness

Diabetic Vision Benefit

Vision care is critical for diabetics. While everyone should get an annual eye exam, diabetics may need to be treated more often because diabetes puts vision at risk.

DeltaVision's Diabetic Vision Benefit includes:

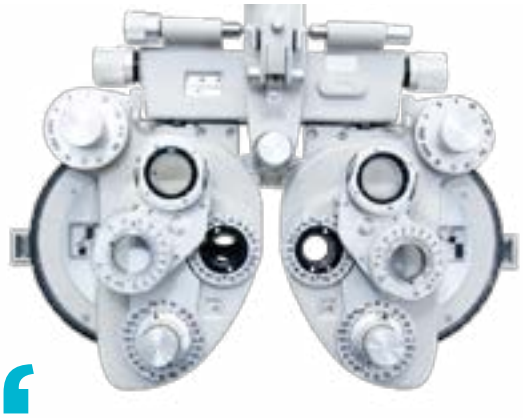
- **An office visit and diagnostic testing every 6 months** in addition to the comprehensive eye exam
- Retinal imaging for a digital image of retina and optic nerve to **help with early diagnosis**
- Extended ophthalmoscopy for **a more detailed examination of the retina**
- Gonioscopy, performed during the eye exam to **evaluate the internal drainage system** of the eye
- Scanning laser, **for sharper images of the retina** than standard exams provide

[1]YourSightMatters.com
[2]American Diabetes Association

Vision Care & Diabetes

The link between vision care and diabetes is strong:

- An **eye exam can help uncover diabetes,** allowing for early treatment[1]
- Diabetes is the **#1 cause of blindness in adults**[2]



"Diabetics are **40% more likely** to have glaucoma, and **60% more likely** to have cataracts."

— American Diabetes Association

FOR MORE VISION CARE INFORMATION

Visit **deltadentalia.com**

DeltaVision® is offered through Veratrus Benefit Solutions, Inc., a wholly-owned subsidiary of Delta Dental of Iowa.

DELTA DENTAL®

2520-F10197 06/2020

DeltaVision®

Annual Eye Exams Just Got Cooler

The One & Sun™ Plan, an Exclusive DeltaVision Benefit

With the One & Sun plan, you can claim a **FREE pair of designer sunglasses** when you get an annual eye exam through your DeltaVision benefits. It's our way of encouraging a healthy habit that could make an important difference, since regular eye exams can help identify early signs of many costly health conditions.[1]

How It Works

1. As an eligible member, when you have a routine eye exam and we receive a qualifying claim, you will automatically receive a unique redemption code in the mail.
2. You will then have 90 days to visit **oneandsun.com** and choose from several top-selling styles.
3. Once you enter your redemption code, provide your shipping address and submit your order, your new sunglasses will arrive within 10 business days.

Why Eye Exams Are Important

Regular eye exams can help **identify early signs of chronic health conditions** like high blood pressure, diabetes, heart disease and high cholesterol.[1]

People are **4 times more likely to get an eye exam than a physical,** so it's often the first sign something is wrong.[2]

[1] American Academy of Ophthalmology: "Frequency of Ocular Examinations"; 2009.
[2] US Department of Health – National Health Statistics Report #8. 8/6/08

DELTA DENTAL®

One & Sun FAQ

Who is eligible to receive free sunglasses?

Only the DeltaVision subscriber/ policyholder and their covered spouse are eligible for this offer. Children are not eligible.

How do you qualify to receive free sunglasses?

DeltaVision subscribers and their covered spouses qualify for free sunglasses when they complete an annual eye exam. Claims for the annual exams must be paid by DeltaVision to automatically qualify. If another plan or carrier covers the eye exam, you will need to apply for an exception.

How long does it take to receive a redemption code?

The unique redemption code will be sent via U.S. Mail to the eligible member's address on file approximately one week after the qualifying claim is received by DeltaVision.

Does the redemption code expire?

Yes. The redemption code must be redeemed within 90 days after it is issued. If the code is not redeemed, the eligible member will be able to take advantage of the program the following calendar year.

Is there any cost for the sunglasses?

No. There is no cost for the sunglasses or shipping/handling. They are 100% free to eligible DeltaVision members.

How often can members get free sunglasses?

Eligible members can receive one free pair of sunglasses every two years, in addition to their regular benefits for prescription lenses and frames. Once the offer has been redeemed, the eligible member must stay on the plan continuously to be eligible for the benefit in alternating years.

How many styles/options are available?

The current selection includes more than ten top styles from Ray-Ban, Oakley, Wiley X and more with an average retail value over $125. Members may only choose from the non-prescription retail stock styles offered at oneandsun.com; prescription sunglasses are not available.

Can the sunglasses be returned or exchanged?

No returns or exchanges are allowed unless your sunglasses arrive damaged. If damaged, an identical replacement will be made free of charge.

How long does it take to receive the sunglasses?

Sunglasses should be delivered within 10 business days after the eligible member redeems their code and submits their order at oneandsun.com.

Visit **oneandsun.com** to browse all available styles and view full program details.

2786-F10317 10/2022

HEARING DISCOUNTS

CITY OF
ames™

MUST BE ENROLLED IN DELTA DENTAL OR DELTA VISION TO QUALIFY FOR DELTA HEARING DISCOUNTS!

DELTA DENTAL®

DeltaVision®

Listen Up

Your ears could be telling you something

Do you often find yourself asking others to repeat themselves? Is there a constant ringing in your ears? If so, your ears could be trying to tell you something.

What causes hearing loss?

Hearing loss is caused by temporary obstructions in the outer or middle ear or permanent damage to the tiny hairs in the inner ear. Common causes of damage include exposure to noise, aging, other health conditions, and certain medications.

When should I get my hearing checked?

Hearing loss can come gradually. You may not even notice it's happening. If your hearing test reports your hearing is okay, stick to once every three to five years. You should test your hearing more often if you are 55 or older or are experiencing any of the following:

- **Consistent exposure** to loud noises
- **Ringing** in your ears
- **Difficulty understanding** in noisy environments or in groups
- **Hearing mumbling** or feeling as though people are not speaking clearly

1 in 9

Americans have hearing loss. By 2030, that number is expected to double.[1]

Delta Dental of Iowa now offers hearing discount benefits.

See back for benefit information >>

FOR MORE INFORMATION
Call 866-925-1698
or visit deltadentalia.com/hearing

[1] https://www.asha.org/articles/untreated-hearing-loss-in-adults/

DELTA DENTAL®

DeltaVision®

Worried about your hearing?
We have you covered.

If you think you may have hearing loss, don't worry. Delta Dental of Iowa has teamed up with Amplifon to offer you quality hearing care.

	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
Hearing Aid Features	Standard features	Additional, easy-to-use functions	Designed for work and play	Enhanced to keep you on the go	Leading technology keeps you connected
One Simple Price	$995/ear	$1,495/ear	$1,795/ear	$2,195/ear	$2,645/ear

\+

Complimentary Aftercare*

Risk-free trial – find your right fit by trying your hearing aids for 60 days
Follow-up care – ensures a smooth transition to your new hearing aids
Battery support – battery supply or charging station to keep you powered
Warranty – 3 year coverage for loss, repairs, or damage

*Risk-free trial - 100% money back guarantee if not completely satisfied, no return or restocking fees. Follow-up care - for one year following purchase. Batteries - two year supply of batteries (80 cells/ear/year) or one standard charger at no additional cost. Warranty - Exclusions and limitations may apply. Contact Client Services (1-844-267-5436) for details.

Amplifon Hearing Health Care is solely responsible for the administration of hearing health care services, and its own financial and contractual obligations. Delta Dental of Iowa and Amplifon are independent, unaffiliated companies. The Amplifon Hearing Health Care discount program is not approved for use with any 3rd party payor program, including government and private third-party payor programs. Hearing services are administered by Amplifon Hearing Health Care, Corp.

Take advantage of these benefits and start hearing better today!

FOR MORE INFORMATION
Call 866-925-1698
or visit deltadentalia.com/hearing

2619-F10222 08/2021

LIFE INSURANCE & DISABILITY

CITY OF
ames™

LIFE INSURANCE AND DISABILITY

Insured by Madison National Life Insurance Company

Life Insurance can help ease the financial and emotional stress associated with the loss of a loved one.

LIFE INSURANCE

Your designated beneficiaries will receive a lump sum payment should you pass away during your employment with the City of Ames. Please see the life insurance certificate for further details.

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Accidental Death and Dismemberment (AD&D) insurance provides payment to you or your beneficiaries if you lose a limb or die in an accident.

City of Ames provides basic Life and AD&D coverage at no cost to you.

CLASS TITLE & ELIGIBILITY (MINIMUM HOUR REQUIREMENT)	BASIC LIFE & AD&D AMOUNTS	SUPPLEMENTAL LIFE & AD&D
Merit Employees working Full-Time (40 hours per week)	$50,000	
Merit Employees working 3/4 Time (30 hours per week)	$37,500	
Merit Employees working 1/2 Time (20 hours per week)	$25,000	
IUOE, IAFF, Electric Distribution Employees, Power Plan Employees working Full-Time (40 hours per week)	$50,000	$10,000 increments to a maximum of $500,000
PPME (40 hours per week)	$50,000	
IUOE Employees working Part-Time (20 hours per week)	$5,000	
PPME, Electric Distribution Employees, Power Plant Employees working Part-Time (20 hours per week)	$2,500	

VOLUNTARY LIFE AND AD&D INSURANCE

You may purchase life and AD&D insurance in addition to the company-provided coverage. You may also purchase life insurance for your dependents if you purchase additional coverage for yourself. You are guaranteed coverage up to $100,000, and up to $25,000 for your spouse, and life insurance for your children up to age 26 without answering medical questions if you enroll when you are first eligible or during annual Open Enrollment.

After initial eligibility, additional coverage may be available for purchase with Evidence of Insurability, as follows:

Employee— Up to five times your salary in increments of $10,000; $10,000; $500,000 maximum amount

Spouse— Up to $25,000 in increments of $5,000, to a maximum of $100,000, not to exceed 50% of employee's approved amount.

Children— $100 for infant; $2,500 child over 6 months to 26 years or $200 for infant; $5,000 child over 6 months to 26 years.

LIFE INSURANCE AND DISABILITY (CONT.)

VOLUNTARY LIFE AD&D RATES

	EMPLOYEE SUPPLEMENTAL LIFE/AD&D	SPOUSE SUPPLEMENTAL LIFE
Less than 30	$.09/$1,000	$.06/$1,000
31-34	$.11/$1,000	$.08/$1,000
35-39	$.13/$1,000	$.10/$1,000
40-44	$.16/$1,000	$.13/$1,000
45-49	$.23/$1,000	$.20/$1,000
50-54	$.34/$1,000	$.31/$1,000
55-59	$.59/$1,000	$.56/$1,000
60-64	$.81/$1,000	$.78/$1,000
65-69	$1.30/$1,000	$1.27/$1,000
70-74	$2.09/$1,000	$2.06/$1,000
75+	$3.21/$1,000	$3.18/$1,000

BENEFICIARY DESIGNATION

Making and maintaining beneficiary designations is an essential part of everyone's financial plan. Neglecting your beneficiary designations might mean that assets that typically avoid probate may become part of your estate and be subject to the associated time and costs of that process. Making and maintaining your beneficiary designations allows you to show your love, appreciation, and support for those important to you.

Be sure to update your beneficiaries when you complete open enrollment this year by contacting Human Resources.

DISABILITY INSURANCE

Meeting your basic living expenses can be a real challenge if you become disabled. Your options may be limited to personal savings, spousal income and possibly Social Security. Disability insurance provides protection for your most valuable asset -- your ability to earn an income. City of Ames provides Long-Term Disability insurance (LTD) coverage for all full-time IPERS employees. Employees participating in the utility retirement program are required to enroll in the disability program and to pay the full premium cost through payroll deduction. Please see the bottom of page 80 for explanation of cost.

LTD coverage provides income when you have been disabled for 60 calendar days or more. Your benefit is 66 2/3% of your monthly earnings, subject to maximum monthly benefit amounts. This amount may be reduced by other deductible sources of income or disability earnings. Benefit payments can continue to age 65 if you are under age 60 at the time of disability.

Eligibility: Insurance becomes effective the first of the month following one year of eligible employment.

HEALTHY 4 LIFE

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CITY OF Ames HEALTH PROMOTION

Vision: To live and work in a healthy culture that values, protects, and enhances wellbeing.

EMPLOYEE WELLNESS SERVICES

MISSION | *We will...*

- Provide employees with the resources, tools and skills to lead healthier lives;
- Empower our workforce to share responsibility for health and well-being;
- Collaborate proactively with management, employees, and health partners to embrace preventative strategies that ensure the sustainability of high quality, affordable health care benefits; and
- Create an enjoyable and stimulating work environment that fosters well-being.

QUESTIONS? CONTACT

Kacie Schumann,
Health Promotion Coordinator
Human Resources

515-239-5354

kacie.schumann@cityofames.org

https://extranet.cityofames.org/myhr/hr/health-promotion/

EMPLOYEE WELLNESS SERVICES OFFERED:

ONSITE VACCINE CLINICS

Free annual flu shots and COVID-19 vaccinations for ALL employees, and family members on City insurance.

FITNESS SUBSIDIES

Heavily discounted Parks & Rec programs and services for those who are eligible for City insurance. Call 515-239-5353 to get started.

HEALTHY4LIFE PROGRAM

Meet certain criteria, get a discount on your health insurance! Program open to those on City insurance. Contact Kacie to get started.

NUTRITION SERVICES

Two free 1:1 nutrition counseling sessions with a registered dietitian for those eligible for City insurance. Contact Susie Roberts at dashccs@gmail.com to get started. We also offer nutrition classes and workshops!

ONSITE HEALTH SCREENINGS

Free annual onsite health screenings for those eligible for City insurance. Includes blood analysis, blood pressure, height, weight, waist circumference, and more!

OTHER EVENTS & RESOURCES

*Blood drives, walking events, health resource library, educational sessions, **and more!***

Healthy 4 Life

EMPLOYEE WELLNESS PROGRAM

Healthy4Life is a FREE, voluntary wellness program that encourages and motivates insured employees in benefits eligible positions to adopt healthy lifestyle behaviors.

JULY 1, 2024 - MAY 31, 2025

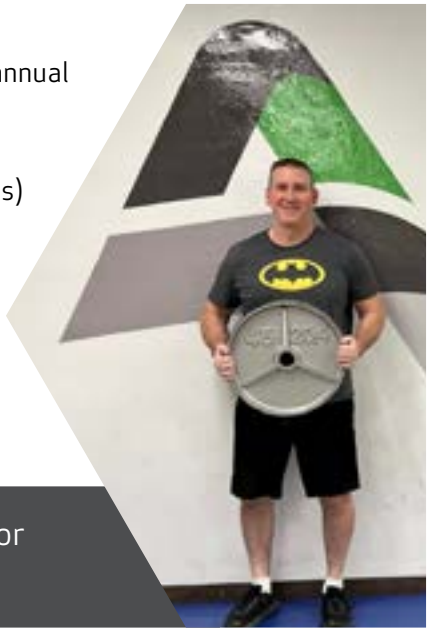
WHY PARTICIPATE?

- Complete certain activities, get a discount on your health insurance!
- You don't need to already be "fit" or "healthy" to join; the goal is to establish healthy behaviors.
- It's confidential! Your coworkers and supervisor won't know anything about your participation unless you choose to tell them. Any coaching sessions or health screenings you choose to engage in follow HIPAA guidance.
- You can get the personalized support you need from certified health professionals, such as health coaches or a registered dietitian!

TO EARN THE DISCOUNT:

- Complete an onsite health screening (offered every July) **OR** go to an annual checkup at your healthcare provider's office. (400 pts)
- Complete an additional medical exam/appointment of your choosing. A list of options will be included with your registration packet. (400 pts)
- Complete one activity related to mental wellbeing. A list of options will be included with your registration packet. (400 pts)
- Get 400 points from participating in other health & wellness activities, such as attending a class or participating in a challenge. A list of options will be included with your registration packet. (400 pts)

*To earn a partial discount, complete 3 out of the above 4.



TO SIGN UP, CONTACT:

Kacie Schumann, Health Promotion Coordinator
515-239-5354 | kacie.schumann@cityofames.org

EMPLOYEE ASSISTANCE PROGRAM

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EFR EMPLOYEE & FAMILY RESOURCES

City of Ames

Call (800) 327-4692 to Access Your Benefit

Employee Assistance Program

Get To Know Your Benefits

Your Employee Assistance Program (EAP) provides a variety of counseling, consultations, resources, and coaching benefits for you and your family members. Your EAP benefits are **cost-free** to you, **confidential**, and available **24/7/365**.

We Can Help With:

- Stress Management
- Relationship Concerns
- Personal Growth
- Anxiety or Depression
- Legal Issues
- Identity Theft
- Tax Questions
- Elder Care
- Financial Concerns
- Budgeting and Debt

EAP Benefit Summary

Phone-Based Support

unlimited

Call us any time you have and issue, concern, or question. You have 24/7 access to masters-level clinicians.

In-Person or Telehealth Counseling

6 sessions per issue per year

Arrange in-person counseling sessions with a licensed mental health therapist near your home or work. Each family member is eligible.

Telephonic Life Coaching

6 sessions per year

Speak with a life coach and receive tailored advice on matters involving time management, work-life integration, goal setting, communication skills, and other areas of personal growth.

Telephonic Financial Consultation

1 30-min session per issue

Speak with a financial professional about each separate issue, and access a free financial check-up, financial library, and a variety of other financial tools by visiting efr.org/financial.

In-Person or Telephonic Legal Consultation

1 30-min session per issue

Meet with a licensed attorney with expertise in your area of need. Visit efr.org/legal for more information regarding retention and self-help legal documents.

Eldercare Resources

as needed

Access information, referral resources, and support involving the care for an aging family member.

Childcare Resources

as needed

Receive childcare resource referrals where locally available. All referrals are state licensed/ certified childcare providers.

Identity Theft Resolution Services

as needed

Receive assistance with restoring identity and good credit from a highly trained FCRA certified fraud resolution specialist or licensed attorney.

Additional Benefits

provided regularly

Stay up-to-date by reading our monthly newsletter, watching our webinars, and/or completing self-assessments. Visit efr.org for more information.

Life Happens. We're Here to Help.

Get Connected: | **505 Fifth Ave, Suite 600** | **efr.org/myeap**

EFR EMPLOYEE & FAMILY RESOURCES

Understanding Your EAP Benefits

EFR is dedicated to helping people manage life's challenges so they can reach their full potential.

When should I call the EAP?

Call **800-327-4692** whenever you are experiencing one of life's challenges. We are available 24/7/365.

What happens when I call?

A representative from EFR will answer your call. The representative will gather demographic information and help you connect with an EAP counselor.

You will be connected with a masters-level clinician to discuss your issues, concerns, or struggles.

What happens when I see the EAP counselor?

- The master's level EAP counselor will listen to your concerns.
- The counselor will also help you explore other areas of your life to assess for strengths and supports, or factors contributing to your presenting issue or concern.
- The counselor will meet with you up to *6* **sessions** to complete a comprehensive assessment of your current circumstances and work with you to establish a plan for EAP sessions.

Options for EAP sessions include:

- Assessment completed and remaining sessions are used for brief counseling and problem resolution.
- Assessment completed and a referral is recommended for services that fall outside the scope of EAP services.

Common Questions

Can I use the EAP more than once a year?

- Yes, but each time you use the EAP, the counselor will be assessing your life circumstances so you will be eligible for a new set of *6* **sessions** if your circumstances have changed, or in 12 months, whichever comes first.

What is a new set of circumstances?

- A new development in your life that has changed since your last EAP assessment.

Why can't I use the EAP more often?

- EAP is an assessment, referral, and brief counseling model to assist employees with managing a wide variety of personal issues, but is not intended to replace therapy, treatment, or ongoing counseling.

Call EFR today!

800-327-4692

505 5th Avenue | Des Moines, IA 50309 | www.efr.org

Understanding-Your-EAP-Benefits-3-session-06090-1

EMPLOYEE DEVELOPMENT

In the spirit of our ETP culture and supporting "continuous improvement" and many other of our values for our employees, the City of Ames has a policy regarding the promotion of continued education to help employees on their professional and personal development. Employees are encouraged to improve their job-related knowledge, skills and abilities throughout their careers. The City provides support for employee development in a variety of ways.

- Employee Development Center programs sponsored by Human Resources
- Department-specific training and development
- Professional development (conferences, outside training opportunities)
- Educational assistance for college coursework (either reimbursement for tuition and fees orlimited time off with pay during regular working hours)

EMPLOYEE DEVELOPMENT CENTER PROGRAMS

Human Resources provides a course list for each semester. These courses are offered to all employees free of charge, upon approval by their supervisor. Formal Leaders also have opportunities to attend Power Hour classes, among other workshops and training classes intended to assist leaders in their roles.

EDUCATIONAL ASSISTANCE PROGRAM

Employees must have completed their six-month probationary period in order to be eligible for participation in this program. This program supports employees who wish to continue their education in support of their current position to grow with the organization through classes or courses that are not offered through the EDC. There are two opportunities to use the program: reimbursement for educational expenses or time off with pay. The approval for such a benefit is provided through an application process. Educational assistance shall not be considered an employee right, but shall be granted at the discretion of management.

For further information or sharing questions regarding these benefits, employees may contact the Human Resources office by calling 515-239-5199 or emailing HR@cityofames.org, or review the Employee Development policy.

PAID TIME OFF BENEFITS

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VACATION

Full-time and part-time employees accrue vacation hours on a monthly basis. The following matrix shows the steps in increased increments.

	HOURS PER YEAR							
Months of Employment	FT Merit, IUOE, Power Plant	1/2 Time Merit, IUOE	3/4 Time Merit, IUOE	FT IAFF	FT Electric Dist. Employees	FT PPME	1/2 Time PPME	3/4 Time PPME
1st through 84th month	80	40	60	112	80	80	40	60
85th through 168th month	120	60	90	168	120	120	60	90
169th through 275th month				224				
169th through 252nd month						160	80	120
169th through 276th month	160	80	120		160			
253rd or more months						200	100	150
276th or more months				280				
277th or more months	200	100	150		200			

Based on either an 8 hours day, 1/2 time 4 hour day, 3/4 time 6 hour day, or IAFF 24 hour shift.

SICK LEAVE

Full-time and part-time employees accrue sick leave on a monthly basis. There is also a certain amount of these hours we allow employees to take on behalf of caring for an immediate family member, as defined under our Family Sick Leave policy or your group's current bargaining unit contract. See the chart below for the amount of accrual hours you are eligible.

	FT Merit & Electric Dist Emp.	FT PPME	IUOE	Power Plant	1/2 Time (Hours) Merit, IUOE	3/4 Time (Hours) Merit, IUOE	IAFF	1/2 Time (hours) PPME	3/4 Time (hours) PPME
Accrual hours per month	8	8	8	8	4	6	24 or 8*	4	6
Hours can use per fiscal year for Family Sick Leave	40	40	40	40	20	30	56 or 40*	20	30

*Depends on how many hours the employee works per week regularly.

WELLNESS DAY (PPME EMPLOYEES ONLY)

All PPME employees who abstain from habitual tobacco use, complete the fitness test(s) using protocols of ILEA (Iowa Law Enforcement Academy) each year, and have accumulated at least 24 hours of sick leave, shall be able to convert one regular work day of time of accumulated sick leave to one paid wellness day off per calendar year.

EMERGENCY LEAVE

All regular employees have this benefit as defined by the Emergency Leave policy. The IAFF bargaining unit contract also has this specific benefit defined for covered employees.

PERSONAL EMERGENCY LEAVE (IAFF EMPLOYEES ONLY)

Emergency leave of up to 24 hours at one time without loss of pay, to a maximum of 24 hours in any calendar year, may be granted to full-time regular and probationary employees for other personal family emergencies upon request to the Fire Chief. These hours will not be charged to sick leave, holiday pay, or vacation hours. Please see the current IAFF bargaining unit contract for specific language for approval and application.

PERSONAL DAY (CERTAIN ELECTRIC DISTRIBUTION EMPLOYEES)

Certain Electric Distribution employees will receive one (1) eight (8) hour paid personal day per fiscal year. Please see the current temporary special employment policy booklet for this group for specific language for approval and application.

HOLIDAYS

The following shall be holidays for employees of the City of Ames:

- New Year's Day
- President's Day
- Memorial Day
- Independence Day
- Labor Day
- Veteran's Day
- Thanksgiving Day
- The Friday following Thanksgiving Day
- Christmas Day
- A floating Christmas holiday

Employees covered by the PPME bargaining unit are awarded a total of 115 days off per year (two days off each week, or one hundred four days, ten paid holidays, plus an additional personal day off during the year). Please see the current PPME bargaining unit contract for specific language and coverage.

Employees covered by the IAFF bargaining unit, if a City holiday falls under a normal shift duty day, personnel will be compensated for these holidays by working a holiday routine tour of duty. Fifty-six hour a week employees covered by the IAFF bargaining unit shall be granted seven floating 24 hour shift holidays in lieu of the ten City holidays. These holidays shall be scheduled with regard to seniority of the employees. Employees under this agreement who work a 40 hour weekly schedule will have a different specified holiday schedule. Please see the current IAFF bargaining unit contract for specific language for approval and application.

RETIREMENT & DEFERRED COMPENSATION

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RETIREMENT

RETIREMENT

Municipal Fire and Police Retirement Systems of Iowa (MFPRSI) is a retirement system only for all sworn Firefighters and Police Officers. See page 71 for further details on this benefit.

All of the City of Ames employees who are not covered by MFPRSI and who work over 1,040 hours or more in a calendar year or earn $1,000 or more in two consecutive quarters are required to participate in IPERS coverage. IPERS is the Iowa Public Employees' Retirement System.

There is only one alternative retirement program for employees who are not covered by MFPRSI, yet have their salary funded at least 10% by Utility revenue. These employees can select to participate in the Utility Retirement Program, a 401(a) defined contribution program managed by Vanguard.

Human Resources will be able to assist you with determining which retirement plan you are eligible.

RETIREMENT COMPARISON CHART

RETIREMENT SYSTEMS		
	IPERS (Defined Benefit)	UTILITY (Vanguard) (Defined Contribution - 401(a))
Eligibility	All City Employees	Non-temporary employees with at least 10% of salary funded by utility revenue. (PW exception)
Contributions	% of Salary	% of Salary
Employee	6.29	5.40
City	9.44	7.93
Maximum Covered Wages	None	None
Administered by	Board reporting to State of Iowa	Board reporting to City Council
Normal Retirement		
Age	65 or Rule of 88: age + at least 30 years of service = 88 or Rule of 62/20: age 62 with 20 years of service	55 or later
Benefit	Multiplier x highest 5-year average salary	The total of member's account is fully portable to another employer's plan or to an IRA account
Early Retirement		
Age	55	
Benefit	The amount lifetime monthly benefits are reduced for early retirement is 6% times the number of years the member receives benefits before age 65	
Number of Years to Vest	7 or age 65	Immediate
Waiting Period	None	None (May not be able to enroll at a later time if waive Utility retirement during the initial 30-day eligibility enrollment period. May not re-enroll if voluntarily withdraw.
Disability		
Waiting Period	One year wait to enroll	One year wait to enroll
Effective Date	61st day of disability	61st day of disability
Benefit	66 2/3% (benefit percentage) of basic monthly earnings, less other income benefits. Insurance will be adjusted if combined income sources exceed 80%). Three-year period.	66 2/3% (benefit percentage) of basic monthly earnings, less other income benefits. Insurance will be adjusted if combined income sources exceed 80%). Three-year period. (Note: Participant pays premium 0.46% of earnings)

MUNICIPAL FIRE AND POLICE RETIREMENT SYSTEM OF IOWA (MFPRSI)

MFPRSI provides a comprehensive set of retirement and disability benefits to eligible local police officers and firefighters in a sound, sustainable, and efficient manner in accordance with the requirements of the program's governing statute.

Police eligibility: Members of a police department who have passed a regular mental and physical civil service examination for police officers, and who have been duly appointed to such positions. Such members include patrol officers, sergeants, lieutenants, captains, detectives, and other senior officers who are so employed for police duty.

Fire eligibility: An employee who meets the membership requirements established by the state law for the Fire Retirement System for the City of Ames shall be a member of the system as a condition of his/her employment.

Rates as of July 1, 2024

Employer Contribution Rate: 22.66%

Employee Contribution Rate: 9.55%

Contact MFPRSI at
http://www.mfprsi.org or
Toll-Free (888) 254.9200

DEFERRED COMPENSATION

Administered by Mission Square

The 457 Deferred Compensation Plan is designed to supplement your retirement income. While a pension and/or Social Security will go a long way, they are unlikely to be enough. Saving to your 457 plan can help you maintain your desired standard of living. This program is a pre-tax savings program, limited to government employees (and some not-for-profit organizations). Each 457 participant develops his or her own portfolio and investment strategies.

Current limit to invest per year is $23,000. Employees age 50 or older may contribute up to an additional $7,500 for a total of $30,500. Since participation is optional, you may enroll at any time during your employment with the City.

MissionSquare RETIREMENT

2024 Retirement Plan Contribution Limits

The IRS has announced updated retirement plan contribution limits for 2024. Below is a snapshot of the updated limits:

Plan or Account Type	2024	2023
457(b)	**$23,000**	$22,500
401(a)*	**$69,000**	$66,000
401(k)	**$23,000**	$22,500
403(b)	**$23,000**	$22,500
Traditional and Roth IRAs	**$7,000**	$6,500

- More information about the 2024 contribution limits, including the Age 50 Catch-Up and Pre-Retirement Catch-Up limits, is available at www.missionsq.org/contributionlimits.
- Detailed information is available from the IRS.
- **Take Action:** Even a small increase can go a long way to securing your retirement. Log in to your MissionSquare account today to increase your contribution.

Questions? Contact your MissionSquare Retirement Plans Specialist for more information.

*Limitations may apply to defined benefit plans. Please contact your defined benefit plan administrator should you require additional information.

MissionSquare Retirement 777 N. Capitol Street, NE, Washington, DC 20002-4240
www.missionsq.org

63474-1123-W3227

Why a Roth IRA?

A Roth IRA is a savings vehicle that can complement your employer retirement plans by allowing for tax-free earnings and, if needed, flexible withdrawals. MissionSquare's Payroll Roth IRA allows you to make convenient contributions directly from your paycheck.

Boost Your Savings

What are your savings goals? A Roth IRA can help you:

- Earn additional retirement income

- Set aside money in retirement for travel, gifts, or medical care

- Make a down payment on a home

- Pay for a child's college education

- Build an emergency fund

Diversify Your Taxes with Tax-Free Earnings

A Roth IRA can help you manage your tax bill because withdrawals, including all earnings, may be **tax-free**. This can help offset withdrawals of other taxable employer plan and IRA assets. It may also help minimize taxation of Social Security benefits or surcharges on Medicare premiums.

Control and Flexibility

The longer your Roth IRA is invested, the larger the potential tax-free growth, and you retain full access to your assets. Contributions can be withdrawn without taxes or penalties.

Match a Roth IRA with Your 457 Plan

Saving to a Roth IRA and your 457 plan may make sense because they complement each other.

Visit **www.icmarc.org/contributionlimits** to view current year annual maximum contribution amounts.

Why a Payroll Roth IRA?

Simple and Convenient

A MissionSquare Retirement Payroll Roth IRA makes saving simple and convenient through automatic paycheck contributions that you can change at any time.

There are no maintenance fees,* you can contribute as little as $10 per pay period, and you can view your account alongside your other MissionSquare accounts on your quarterly statement and our website (www.missionsq.org).

Small Saving + Tax-Free Compounding

Contributing $25 biweekly to start, and increasing that by just $5 per year can really add up due to compounding earnings. And those earnings can be tax-free.

For illustrative purposes only. Assumes effective annual rate of 6%, compounded biweekly and $25 biweekly contributions the first year, with a $5 yearly increase thereafter ($30 biweekly the second year, $35 the third year, etc.).

Investment Options

To help you choose and manage your investments visit www.icmarc.org/irainvest and www.icmarc.org/guidedpathways.

* There are ongoing fees associated with the investments in the account and fees for optional services may also apply.

Understanding Roth IRA Contributions

You have to be eligible to contribute to a Roth IRA based on your modified adjusted gross income, which is generally all of your income subject to taxes, certain deductions, and your filing status.

There are also IRS limits on how much you can contribute to a Roth IRA.

You can make current tax-year contributions until the next year's tax-filing deadline.*

Saver's Credit

You may be eligible for a tax credit of as much as $2,000 ($4,000 if married filing jointly) if you qualify based on your income. Visit **www.icmarc.org/saverscredit** to learn more.

Spousal IRA

Your spouse may also make IRA contributions, based on your income, regardless of whether he/she earns income. To open an IRA for your spouse, visit **www.icmarc.org/ira**.

Understanding Roth IRA Conversions

You may transfer – or convert – assets from a traditional IRA or, if eligible, employer plan, to a Roth IRA. The assets converted are subject to tax but future earnings may be tax-free. Visit **www.icmarc.org/rothconversion** to learn more. In addition to taxes, you should consider the services, investments, and costs associated with both accounts.

* Current year paycheck contributions can only be made through the final pay period of the year, but prior year contributions (or additional current year contributions) may be made by sending separate payments.

Understanding Roth IRA Withdrawals

Roth IRA withdrawals can be made at any time, and your contributions can always be withdrawn without taxes. Withdrawals, including earnings, are **100% tax-free** if you have held a Roth IRA account for at least five years, as defined by the IRS, **and any of the following apply:**

- You are at least age 59½.
- You have a qualifying "first-time" home purchase (limited to $10,000 in traditional IRA assets and/or Roth IRA earnings over your lifetime).
- You have a qualifying disability.
- Your beneficiaries or heirs receive the assets after your death.

Otherwise:

- The first assets withdrawn are your contributions, which are never subject to taxes or penalties.
- The next assets withdrawn are converted assets, which may be subject to a 10% penalty tax if withdrawn within five years of the conversion and you are under the age of 59½, unless you qualify for an exception.
- The last assets withdrawn are earnings, which may be subject to ordinary income taxes and, if you are under the age of 59½, the 10% penalty tax, unless you qualify for an exception.

Penalty-Free Withdrawals

Withdrawals subject to ordinary income taxes can avoid the IRS 10% penalty tax if you qualify for an exception, including payment of qualifying:

- Higher education expenses, including tuition, fees and books, for you, your spouse, children and grandchildren
- Major medical expenses
- Health insurance premiums while unemployed

Additional exceptions may apply. See IRS Publication 590 for a complete list (www.irs.gov).

Required Minimum Distributions Do Not Apply

Unlike traditional IRAs and employer retirement plans, Roth IRAs are not subject to required minimum distributions (RMDs), allowing you to increase potential tax-free growth in your later retirement years and/or for your loved ones after you die.

MissionSquare Retirement does not provide specific tax or legal advice.

EMPLOYEE CONTRIBUTIONS

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EMPLOYEE CONTRIBUTIONS

Medical and dental premium rates are separate, however Classic Blue is a closed Medical plan. You will be able to select any dental plan to pair with your medical plan, or you can elect your medical separately.

Premium contributions for 2024 - 2025 are as follows:

MEDICAL	MONTHLY
Blue Advantage	
Single	$41.14
3/4 Single	$236.54
1/2 Single	$431.94
Family	$88.82
3/4 Family	$510.70
1/2 Family	$932.60
Alliance Select	
Single	$116.08
3/4 Single	$377.26
1/2 Single	$638.44
Family	$270.50
3/4 Family	$879.16
1/2 Family	$1,487.80
Classic Blue®	
Single	$151.64
3/4 Single	$492.86
1/2 Single	$834.08
Family	$355.66
3/4 Family	$1,155.90
1/2 Family	$1,956.14

*The employee contribution rate may change if an employment status change occurs.

DENTAL	MONTHLY	
Plan 1	**(w/Classic Blue or Alliance Select)**	**(w/Blue Advantage)**
Single	$3.74	$1.86
3/4 Single	$12.16	$10.74
1/2 Single	$20.56	$19.64
Family	$8.82	$4.40
3/4 Family	$28.68	$25.36
1/2 Family	$48.54	$46.34
Plan 2	**(w/Classic Blue or Alliance Select)**	**(w/Blue Advantage)**
Single	$9.90	$7.74
3/4 Single	$19.58	$17.96
1/2 Single	$29.24	$28.18
Family	$23.38	$18.32
3/4 Family	$46.22	$42.42
1/2 Family	$69.06	$66.52
VISION - BASE PLAN	**MONTHLY (TOTAL PREMIUM)**	
Single Coverage	$7.08	
Employee + Spouse	$13.46	
Employee + Children	$15.26	
Family	$20.12	
VISION - BUY-UP PLAN	**MONTHLY (TOTAL PREMIUM)**	
Single Coverage	$9.58	
Employee + Spouse	$18.36	
Employee + Children	$17.76	
Family	$25.02	

Retiree Medical Rates - Monthly	Single	Family
Blue Advantage	$822.76	$1,776.38
Alliance Select	$1,160.82	$2,705.10
Classic Blue®	$1,516.50	$3,556.62

Retiree Dental Rates - Monthly	Single	Family
Dental Plan 1	$37.40	$88.26
Dental Plan 2	$43.00	$101.50

Retiree Vision Rates - Monthly	Base Plan Rates	Buy-Up Plan Rates
Employee	$7.08	$9.58
Employee + Spouse	$13.46	$18.36
Employee + Child(ren)	$15.26	$17.76
Family	$20.12	$25.02

If you are enrolled in **HEALTHY FOR LIFE** as you leave the City, you may enroll in COBRA for this benefit as long as you are enrolling in medical COBRA.

COBRA		Monthly Premium
Blue Advantage	• Covered Employee Only • Spouse/Ex-Spouse Only • Dependent Child Only	$839.22
	• Covered Employee and Spouse • Covered Emp. & 1 or more Dependent • Spouse/Ex-Spouse and 1 or more Dependent • Covered Emp., Spouse, and 1 or moreDependent	$1,811.91
Alliance Select	• Covered Employee Only • Spouse/Ex-Spouse Only • Dependent Child Only	$1,184.04
	• Covered Employee and Spouse • Covered Emp. & 1 or more Dependent • Spouse/Ex-Spouse and 1 or more Dependent • Covered Emp., Spouse, and 1 or moreDependent	$2,759.20
Classic Blue®	• Covered Employee Only • Spouse/Ex-Spouse Only • Dependent Child Only	$1,546.83
	• Covered Employee and Spouse • Covered Emp. & 1 or more Dependent • Spouse/Ex-Spouse and 1 or more Dependent • Covered Emp., Spouse, and 1 or moreDependent	$3,627.75
Dental Plan 1	• Covered Employee Only • Spouse/Ex-Spouse Only • Dependent Child Only	$38.15
	• Covered Employee and Spouse • Covered Emp. & 1 or more Dependent • Spouse/Ex-Spouse and 1 or more Dependent • Covered Emp., Spouse, and 1 or moreDependent	$90.03
Dental Plan 2	• Covered Employee Only • Spouse/Ex-Spouse Only • Dependent Child Only	$43.86
	• Covered Employee and Spouse • Covered Emp. & 1 or more Dependent • Spouse/Ex-Spouse and 1 or more Dependent • Covered Emp., Spouse, and 1 or moreDependent	$103.53
Vision - Base Plan	• Covered Employee Only • Covered Employee and Spouse • Covered Employee And Children • Family	$7.22 $13.73 $15.57 $20.52
Vision - Buy-Up Plan	• Covered Employee Only • Covered Employee and Spouse • Covered Employee And Children • Family	$9.77 $18.73 $18.12 $25.52

IMPORTANT CONTACTS

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IMPORTANT CONTACTS

BENEFIT	ADMINISTRATOR	PHONE	WEBSITE/EMAIL
Medical	Wellmark Blue Cross/Blue Shield	800.524.9242	www.MyWellmark.com
Prescription	Carelon	833-320-1156	www.carelonrx.com
FSA	TASC	800.422.4661	www.tasconline.com
First Nurse (24/7)	Mary Greeley Medical Center	515.239.6877 (Ames) 800.524.6877 (Anywhere in Iowa)	www.mgmc.org/medical-services/first-nurse/
BeWell 24/7SM	Wellmark	844.84.BEWELL or 844.842.3955	
Dental	Delta Dental	800.544.0718	www.deltadental.ia.com
Dental Discount Plan	Chewsi	515.823.8514	www.chewsidental.com
Vision	Delta Vision	888.899.3747	www.deltadentalia.com/deltavision
Life AD&D	Madison National Life Insurance Company	515.239.5199	HR@CityofAmes.org
Voluntary Life AD&D	Madison National Life Insurance Company	515.239.5199	HR@CityofAmes.org
Long-Term Disability	Madison National Life Insurance Company	515.239.5199	HR@CityofAmes.org
EAP	Employee and Family Services (EFR)	800.327.4692	www.efr.org/myeap
Retirement	IPERS	800.622.3849	www.ipers.org
	MFPRSI	888.254.9200	www.mfprsi.org
	Deferred Compensation Mission Square, Michael McIntosh	866.731.1048	mmcintosh@missionsq.org www.missonsq.org
	Vanguard	800.523.1188	www.vanguard.com
Human Resources	Human Resources	515.239.5199	HR@CityofAmes.org

COMPLIANCE NOTICES AND INFORMATION

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NOTICES

PATIENT PROTECTIONS DISCLOSURE

The City of Ames Health Plan generally may require the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Wellmark Blue Cross/Blue Shield designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Wellmark Blue Cross/Blue Shield at 800.524.9242 or www.MyWellmark.com.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Wellmark Blue Cross/Blue Shield or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Wellmark Blue Cross/Blue Shield at 800.524.9242 or www.MyWellmark.com.

WOMEN'S HEALTH AND CANCER RIGHTS ACT 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 the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: COA Blue Advantage HMO (Individual: 0% coinsurance and $0 deductible; Family: 0% coinsurance and $0 deductible)
Plan 2: COA Alliance Select PPO (Individual: 10% coinsurance and $100 deductible; Family: 10% coinsurance and $200 deductible)
Plan 3: COA Classic Blue (Closed Plan) (Individual: 10% coinsurance and $100 deductible; Family: 10% coinsurance and $200 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 515.239.5199 or hr@cityofames.org.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

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 January 31, 2023. Contact your State for more information on eligibility –

ALABAMA Medicaid	ALASKA Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS Medicaid	**CALIFORNIA Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA Medicaid	**INDIANA Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584

IOWA Medicaid and CHIP (Hawki)	KANSAS Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
KENTUCKY Medicaid	**LOUISIANA Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE Medicaid	**MASSACHUSETTS Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711 Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
MINNESOTA Medicaid	**MISSOURI Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA Medicaid	**NEBRASKA Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA Medicaid	**NEW HAMPSHIRE Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY Medicaid and CHIP	**NEW YORK Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA Medicaid	**NORTH DAKOTA Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

OKLAHOMA Medicaid and CHIP	OREGON Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA Medicaid and CHIP	**RHODE ISLAND Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA Medicaid	**SOUTH DAKOTA Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS Medicaid	**UTAH Medicaid and CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT Medicaid	**VIRGINIA Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON Medicaid	**WEST VIRGINIA Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN Medicaid and CHIP	**WYOMING Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 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

PAPERWORK REDUCTION ACT STATEMENT

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

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.
OMB Control Number 1210-0137 (expires 1/31/2026)

IMPORTANT WARNING

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

THIS 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.

OUR ORGANZIATIONS'S PLEDGE TO YOU

We are required by applicable federal and state law to inform you of our privacy practices and our legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan.

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. We require all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

PROTECTED HEALTH INFORMATION

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

HOW WE MAY USE YOUR PROTECTED HEALTH INFORMATION

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

PAYMENT. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

HEALTH CARE OPERATIONS. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.
However, we are prohibited from using or disclosing protected health information that is genetic information for our underwriting purposes.

TREATMENT. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

AS PERMITTED OR REQUIRED BY LAW. We may also use or disclose your protected health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

PURSUANT TO YOUR AUTHORIZATION. When required by law, we will ask for your written authorization before using or disclosing your protected health information. Uses and disclosures not described in this notice will only be made with your written authorization. Subject to some limited exceptions, your written authorization is required for the sale of protected health information and for the use or disclosure of protected health information for marketing purposes. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

TO BUSINESS ASSOCIATES. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

TO THE PLAN SPONSOR. We may disclose protected health information to certain employees for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

YOUR RIGHTS

RIGHT TO INSPECT AND COPY. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

RIGHT TO AMEND. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

RIGHT TO AN ACCOUNTING OF DISCLOSURES. You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures.

Your request to for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

RIGHT TO REQUEST RESTRICTIONS. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend. Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

RIGHT TO BE NOTIFIED OF A BREACH. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

RIGHT TO RECEIVE A PAPER COPY OF THIS NOTICE. If this notice is provided electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

OUR LEGAL RESPONSIBILITIES

We are required by law to maintain the privacy of your protected health information, provide you with this notice about our legal duties and privacy practices with respect to protected health information and notify affected individuals following a breach of unsecured protected health information.

We may change our policies at any time and reserve the right to make the change effective for all protective health information that we maintain. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

IF YOU HAVE ANY QUESTIONS OR COMPLAINTS, PLEASE CONTACT:

Contact Office	Human Resources
Name of Company	City of Ames
Street Address	515 Clark Ave
City, State Zip	Ames, IA 50010
Phone Number	515-239-5199
Email Address	hr@cityofames.org

AMENDMENT AND CERTIFICATION

AMENDMENT

This notice will serve as an amendment to our health insurance plan document to:

- Establish the permitted and required uses and disclosures of PHI by us and
- Provide that the group health plan will disclose PHI to us only upon receipt of a certification that the plan documents have been amended to incorporate the required provisions and that we agree to comply with privacy regulations.

CERTIFICATION

We hereby certify that the plan document of our Group Health Plan has been amended to comply with the requirements of 45 Code of Federal Regulations 164.504(f)(2). The amendment provides the required assurance that the we will appropriately safeguard and limit the use and disclosure of the Group Health Plan participants' protected health information that the we may receive from the Group ealth Plan or from the Insurance Carrier to perform the plan administration functions.

COMPLAINTS

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

This form does not constitute legal advice and is provided "as is." This form is based upon current federal law and is subject to change based upon changes in federal law or subsequent interpretive guidance. This form must be modified to reflect the user's privacy practices and its state law where the state law is more stringent.

Eff. 2-28-13

HIPAA SPECIAL ENROLLMENT RIGHTS

City of Ames Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the City of Ames Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 45 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 45 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Krista Hammer - Human Resources Officer at 515.239.5199 or hr@cityofames.org.

NOTICE OF CREDITABLE COVERAGE

IMPORTANT NOTICE FROM CITY OF AMES

About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Ames and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage ifyou join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offersprescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Someplans may also offer more coverage for a higher monthly premium.
2. City of Ames has determined that the prescription drug coverage offered by the medical plan is, on average for all planparticipants, expected to pay out as much as standard Medicare prescription drug coverage pays and is thereforeconsidered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverageand not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current City of Ames coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.

If you do decide to join a Medicare drug plan and drop your current City of Ames coverage, be aware that you and your dependents may be able to get this coverage back. If you are still a benefit eligible employee of the City and you enroll during an open enrollment period.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage with City of Ames and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Ames changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

FOR MORE INFORMATION ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbookfor their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

REMEMBER: Keep this Creditable Coverage Notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	July 01, 2024
Name of Entity/Sender:	City of Ames
Contact—Position/Office:	Krista Hammer—Human Resources Officer
Office Address:	515 Clark Ave. Ames, Iowa 50010 United States
Phone Number:	515.239.5199

Model General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)
** Continuation Coverage Rights Under COBRA**

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 must pay for COBRA continuation coverage.

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-employee's 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."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to City of Ames, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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. You must provide this notice to: Krista Hammer.

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 COVERAGE

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 don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period1 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 health plan 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.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

For more information visit https://www.medicare.gov/medicare-and-you.

IF YOU HAVE QUESTIONS

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

CITY OF AMES
VICKI HILLOCK — HUMAN RESOURCES SECRETARY 515 CLARK AVE.
AMES, IOWA 50010 UNITED STATES
515.239.5199

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

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

WHAT IS "BALANCE BILLING" (SOMETIMES CALLED "SURPRISE BILLING")?

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

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

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

You are protected from balance billing for:

EMERGENCY SERVICES

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be 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 never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would payif 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 showthat 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-pocketlimit.

If you believe you've been wrongly billed, you may contact HHS at 1-800-985-3059.
Visit https://clicktime.symantec.com/3XJkGSFcityf21VGt3p2nV76xU?u=https%3A%2F%2Fwww.cms.gov%2Fnosurprises%2Fconsumers for more information about your rights under federal law.

This document is an outline of the coverage proposed by the carrier(s), based on information provided by the City. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

Smart Choice™