Crawford COUNTY • IOWA

2024-2025

EMPLOYEE BENEFITS

TABLE OF CONTENTS

This benefit summary describes the benefit plans available to you as an employee of Crawford County . The details of these plans are contained in the official plan documents that have been provided to you by your employer, including some insurance contacts. This summary is meant only to cover the highlights of each plan. It does not contain all the details that are included in your summary plan description as described by the Employee Retirement Income Security Act (ERISA).

If there is ever a question about one of these plans, or if there is a conflict between the information in this summary and the formal language of the plan documents, the formal wording in the plan documents will govern. Please note that the benefits described in the summary may be changed at any time and do not represent a contractual obligation on the part of Crawford County .

WELCOME!

Welcome to Crawford County! WE ARE COMMITTED to providing competitive benefit programs that are flexible enough to meet your individual needs. Our comprehensive benefits are carefully designed to give you the tools you need to keep you and your family healthy, provide financial protection in the event of unforeseen circumstances and help you build long-term security for retirement.

Getting the most from your benefits is up to you. You know your family, your goals and your lifestyle best.
This benefits guide was designed to answer some of the basic questions you may have about your benefits. Please take the time to review this guide to make sure you understand the benefits that are available to you and your family and be sure to act before the enrollment deadline.

NEW HIRE ENROLLMENT: TAKE ACTION!

If you do not enroll within 30 days of your hire date you will not be able to enroll until the next Open Enrollment, unless you experience a Qualifying Life Event (QLE). Effective date is the first of the month following date of hire. Spouses and dependent children of the employee are also eligible to participate in our benefit plans.

BENEFIT ELIGIBILITY

You and your eligible family members may participate in the 2024 employee benefits program if you're a regular, full-time employee working a minimum of 30 hours per week.

DEPENDENT ELIGIBILITY

You can enroll the following dependents in our group benefit plans:

- Your legal spouse
- Children up to age 26*
- A child under the age of 26 who is your natural child, stepchild, legally adopted child, or child for whom you have obtained legal guardianship
- Unmarried children of any age if totally disabled and claimed as a dependent on your federal income tax return (documentation of handicapped status must be provided)

**Enrolled children lose coverage when they turn 26 and will be mailed COBRA enrollment information.*

QUALIFYING LIFE EVENT

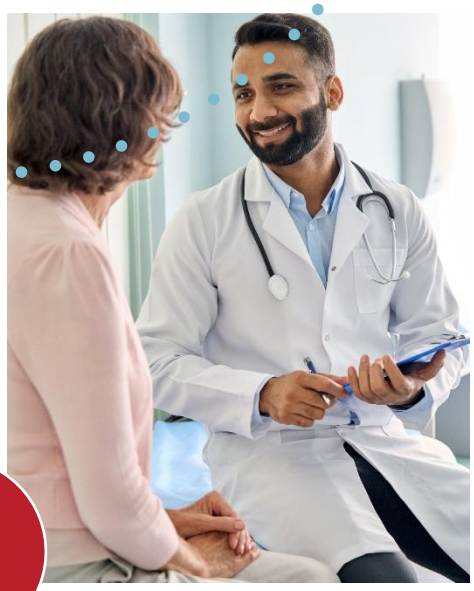
Your benefit elections made during New Hire Enrollment will be effective the first of the month following your hire date. You may not make changes to your elections unless you experience a qualifying life event, including change in legal marital status (marriage, divorce, death of spouse), change in dependents (birth, adoption), change in employment status (termination, part-time), or your spouse's Open Enrollment.

30 days

IMPORTANT

If you need to make a change before the next Open Enrollment period due to a change in status, you must submit the required documentation WITHIN 30 DAYS of the qualifying life change event.

Contact Amy Pieper to process a Qualifying Life Event.



CHOOSE YOUR MEDICAL PLAN

Your medical plans will be offered through Wellmark. Please review your summary of Benefits and Coverage (SBC) for additional coverage information and full plan details.

Elections you make during New Hire Enrollment will be effective the first of the month following your hire date and remain in effect until June 30, 2025, unless you experience a qualifying life event.

You may visit any medical provider you choose, but in-network providers offer the highest level of benefits and lower out-of-pocket costs. In-network providers charge members reduced, contracted rates instead of their typical fees. Providers outside the plan's network set their own rates, so you may be responsible for the difference if a provider's fees are above the Reasonable and Customary (R&C) limits.

REGISTER ONLINE

Your connection to great healthcare is only a click away. Register for an online account at www.Wellmark.com so you can access time- saving tools, tips for healthy living, view lab results, choose a doctor, manage your EOBs, and more!

DOWNLOAD THE MOBILE APP

With the Wellmark mobile app, you've got the tools you need to manage your healthcare all from your smartphone. The mobile app is available in the Apple and Google Play store.

Medical – Monthly Premium	$1,500 Plan	$3,500 HDHP*
Employee	**$122.70**	**$111.79**
Family	**$306.74**	**$279.47**

* Those enrolled in the $3,500 HDHP will receive a monthly Health Savings Account (HSA) contribution of $132.16 for employee-only coverage and $296.42 for family coverage from the County.

MEDICAL PLAN OPTIONS

For more information, please refer to your plan documents	Blue Choice Plan 14 - Traditional	Blue Choice Plan 16 – HSA*
Wellmark → Claims will process to these levels first		
Annual Deductible	$5000 Single $10,000 Family	$6350 Single $12,700 Family
Out-of-Pocket (OOP) Maximum	$9100 Single $18,200 Family	$6350 Single $12,700 Family
Coinsurance	30%	0%
EBS Self-Funded → Claims will be re-processed to these levels		
Annual Deductible	$1500 Single $2500 Family	$3500 Single $7000 Family
Out-of-Pocket (OOP) Maximum	$3000 Single $5000 Family	$3500 Single $7000 Family
Coinsurance	In-Network 80%/20% Out of Network 80%/20%	100%
Doctor of Demand	Medical Visit: $0 Mental Health Visit: $84-$203	Medical Visit: $61 Mental Health Visit: $84-$203
Preventive Care	Covered at 100%	Covered at 100%
Primary Care Physician (PCP)	Coinsurance – Deductible Waived	Deductible
Specialist	Deductible, Coinsurance	Deductible
Urgent Care	Deductible, Coinsurance	Deductible
Emergency Room	Deductible, Coinsurance	Deductible
Inpatient/Outpatient Care	Deductible, Coinsurance	Deductible
Retail Prescription Drugs		
Tier 1/2/3&4	$10/$25/$40 Copay	Deductible
Specialty	$85 Copay	Deductible
Mail Order	2 Copays for 3-Month Supply	Deductible

Please note: Referral may be required to see a specialist.
Please note: If you go to an out-of-network provider, your cost may be higher, and your provider may ask you to pay the actual charge for your care at the time of your visit.
* Those enrolled in the $3,500 HDHP will receive a Health Savings Account (HSA) contribution of $132.16 for employee only coverage and $296.42 for family coverage monthly.

Doctor on Demand

Wellmark uses Doctor on Demand for telehealth services. You can schedule a virtual appointment with board-certified doctors and pediatricians who can diagnose, treat and prescribe most medications for minor medical conditions. Cost is $61 for general healthcare and between $84-$203 for virtual mental health visits.

Get treatment for:

- Cold and flu
- Bronchitis and sinus infections
- Urinary tract infections
- Sore throats
- Allergies
- Fever
- Headache
- Pink eye
- Skin condition
- **Mental health issues** (including anxiety, depression, relationship issues, grief, eating disorders, smoking cessation or alcohol dependence)[2]

Questions? Call 800-997-6196.

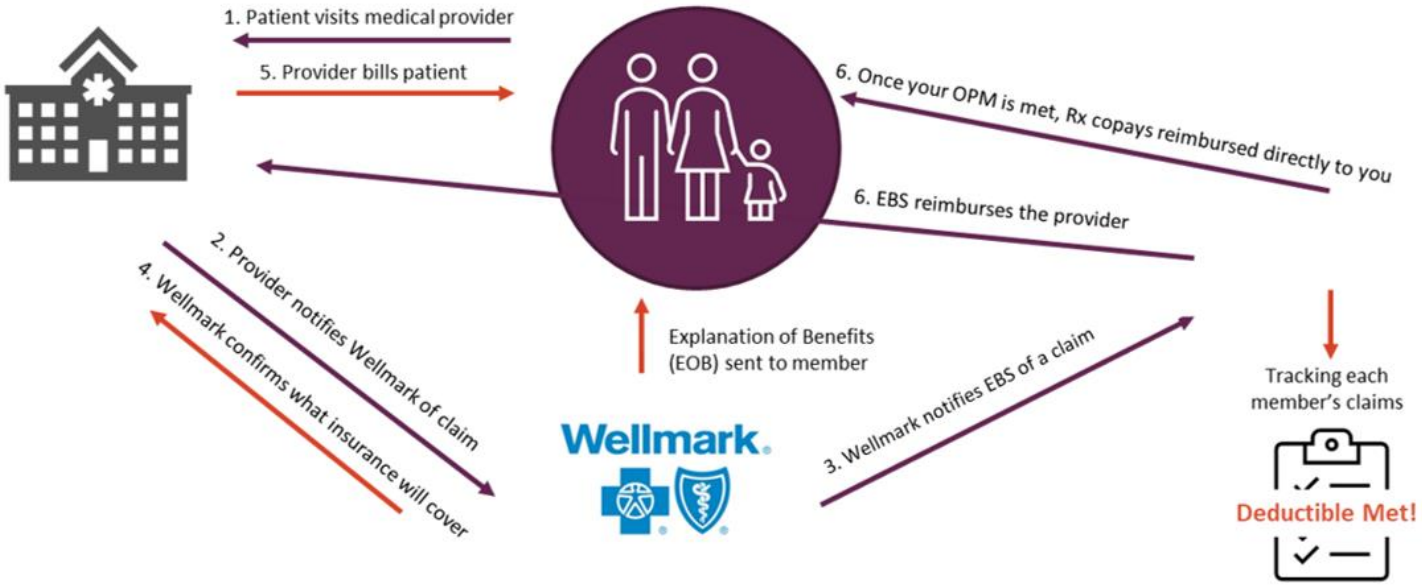
dr. on demand

GETTING STARTED IS EASY.

1. Download the Doctor On Demand® app or visit DoctorOnDemand.com.
2. Have your Wellmark member ID card ready.
3. Create an account or sign in.

PARTIAL SELF-FUNDING AND EBS

What is partial self-funding? Crawford County purchases a higher deductible plan from Wellmark, with higher deductibles and out-of-pocket maximums. Rather than the employee being responsible for meeting the higher deductible and out-of-pocket maximums, Crawford County partners with Employee Benefit Systems (EBS). EBS's role is to reprocess Wellmark's claims to decrease member's responsibilities for the deductible and out-of-pocket maximum.



- How long does it take to receive reimbursement from EBS?
  - Wellmark sends weekly file feeds to EBS. EBS will process then initiate payment to within 2 weeks. To receive your reimbursement quicker, you can enroll in direct deposit.
  - As a reminder, you are only reimbursed for prescription drugs.

- What happens if I met my deductible and OPM, but providers are asking for payment?
  - If you are incurring a medical claim at a medical provider, we encourage you to tell your provider about your buy-down plan and ask they contact EBS. If possible, try to hold off on any payments to avoid being reimbursed.
  - If you are incurring a pharmacy claim at the pharmacist, you will need to pay the full amount of your drug, then wait for reimbursement from EBS.

- What happens if I paid my medical provider when I shouldn't have?
  - EBS will reimburse your medical provider, then your medical provider will be responsible for reimbursing you. This is why we ask that you hold off on any payment if possible.

- Can I put my reimbursement back into my HSA?
  - Yes, if you paid the original claim from your HSA you can put the money back, but you need to make sure your bank knows that this is a refund to your HSA and should not count against your annual maximum.

HEALTH SAVINGS ACCOUNT (HSA)

WHAT IS A HEALTH SAVING ACCOUNT?

A Health Savings Account (HSA) is a way for you to save pre-tax dollars that can be used to pay for qualified healthcare expenses like deductibles, copays, co-insurance, prescriptions, vision and dental expenses. High deductible health plans have lower premiums and may result in lower annual medical costs. These plans offer several advantages to reward you for taking an active role in your healthcare spending.

- **Lower paycheck costs** — allowing you to keep control over more of your money
- **Tax-advantaged savings account** — enrolling in and contributing to a Health Savings Account (HSA) helps you pay your deductible and out-of- pocket costs
- **Comparable benefits** — these plans use the same networks that other plans offer, and in-network preventive care is still 100% covered

WHO IS ELIGIBLE FOR AN HSA?

- Must be enrolled in a high deductible health plan
- Cannot be covered by any other medical plan that is not a qualified HDHP. This includes a spouse's medical coverage unless it's also a qualified HDHP
- Cannot be enrolled in a traditional health care FSA in 2024
- Cannot be enrolled in Medicare, including Parts A or B, Medicaid or Tricare
- Cannot be claimed as a dependent on another person's tax return
- Cannot be a veteran who has received treatment, other than preventive care, through the Department of Veterans Affairs within the past three months

For a list of eligible expenses, see IRS Publication 502, available at www.irs.gov).

HOW MUCH CAN I CONTRIBUTE TO AN HSA?

- Employee only coverage: **$4,150** per calendar year
- Employee plus dependents coverage: **$8,300**
- If you are 55 or older, you can make an additional annual catch-up contribution of **$1,000**
- Those enrolled in the $3,500 HDHP will receive a Health Savings Account (HSA) contribution of $132.16 for employee only coverage and $296.42 for family coverage monthly.

HSAs AND YOUR TAXES

All withdrawals from your HSA are tax-free, as long as you use the money to pay for eligible health care expenses. In addition, all the money in the account is yours and will never be forfeited. It rolls over from year to year, and you can take it with you if you leave the company or retire. After age 65, you can withdraw funds for any reason without a tax penalty — you pay ordinary income tax only if the withdrawal isn't for eligible health care expenses.

Note: You won't pay federal taxes on HSA contributions. However, you may pay state taxes depending on your residence. Consult your tax advisor to learn more.

FLEXIBLE SPENDING ACCOUNT (FSA) - TASC

Tax-advantaged FSAs are a great way to save money. The money you contribute to these accounts comes out of your paycheck without being taxed, and you withdraw it tax-free when you pay for eligible health care and dependent care expenses.

HEALTH CARE FSA

- A FSA is an employer-sponsored savings account for health care expenses. You are not taxed on the money put into the FSA, and you can then use the account to pay for qualified out-of-pocket health care costs, such as your deductible and copays, but not your premiums. Contribute up to **$3,200** in 2024.

FSA is "Use It or Lose It" meaning if you do not spend your funds by the expense deadline, your funds will be forfeited.

- There is a carryover amount of $640.00 for the following plan year. The maximum election will continue to be $3,200; rollover funds will be added to the maximum.
- Dependent Care can only be reimbursed for expenses incurred in the plan year (**7/1/2024** through **6/30/2025**)

Eligible Expenses

(Not an exhaustive list-see the IRS website for more information)

- Medical expenses not paid by insurance
- Dental expenses
- Vision expenses
- Prescription drugs
- Birth control
- Fertility enhancements
- Bandages
- Medical devices
- Chiropractic care
- Acupuncture
- Speech therapy
- Pre & post-natal care
- Home care expenses
- Crutches
- Smoking cessation programs
- Physical therapy
- Laser eye surgery
- Hearing aids & batteries

DEPENDENT CARE FSA

Who can participate?

Any employee.

What are the contribution limits?

Employees can contribute up to **$5,000** annually per family or **$2,500 i**f filing separately.

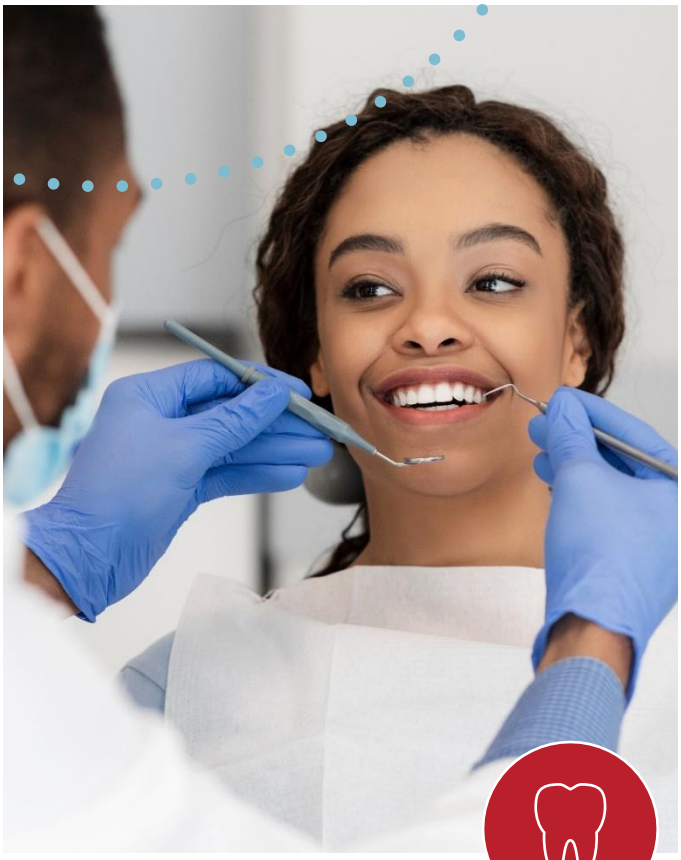
What happens at the end of the year?

Use it or lose it. Unlike the healthcare FSA, your full election for the plan year is not available on the day your plan starts. For the dependent care FSA, you can only be reimbursed for qualified expenses up to the amount you have contributed to your FSA up to that point in time. As your contributions accrue, claims for reimbursement can be processed.

WHAT'S AN ELIGIBLE EXPENSE?

Health Care FSA – Plan deductibles, copays, coinsurance, and other health care expenses. To learn more, see IRS Publication 502 at www.irs.gov.

Dependent Care FSA – Child day care, babysitters, home care for dependent elders, and related expenses. To learn more, see IRS Publication 503 at www.irs.gov.



DENTAL PLAN
DELTA DENTAL

In addition to protecting your smile, dental insurance helps pay for dental care and includes regular checkups, cleanings and x-rays. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery. Dental coverage is offered for basic and major services. The dental plan also includes 100% coverage for preventive care. You and your eligible dependents may enroll in one of the two dental coverage options administered by Delta Dental.

In-Network Plan Features	PPO Network	Premier Network
Annual Deductible – Individual	$15	$25
Annual Deductible – Family	$45	$75
Annual Maximum	$1,500	$1,500
Preventive Care	Covered at 100%	Covered at 100%
Basic Services	10% after deductible	20% after deductible
Major Services	50% after deductible	50% after deductible
Orthodontia Services	50% Coinsurance	50% Coinsurance

Dental	Monthly Premium
Employee	$6.27
Family	$82.69

VISION PLAN
VSP

Driving to work, reading a news article and watching TV are all activities you likely perform every day. Your ability to do all of these activities, though, depends on your vision and eye health.
Vision insurance can help you maintain your vision as well as detect various health problems.

Your vision insurance is provided by VSP and entitles you to specific eye
care benefits. Our policy covers routine eye exams and other procedures, and provides specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses.

	In Network	Out Of Network
Office Visit		
Annual Deductible – Family	$20 Copay	Up to $45
Eyeglass Lenses Materials & Framesv		
Single Vision Lenses	$20 Copay	Up to $30
Standard Lined Bifocal Lenses	$20 Copay	Up to $50
Standard Trifocal Lenses	$20 Copay	Up to $65
Frames	$20 Copay	Up to $70
Contact Lens	$130 Allowance	Up to $105
Additional Glasses & Sunglasses Discount	20% Discount	N/A
Frequency of Services		
Comprehensive Eye Exam	Once every 12 months	
Lenses	Once every 12 months	
Frames	Once every 24 months	
Contact Lenses	Once every 12 months	

Vision	Monthly Premium
Employee	$14.04
Employee + Spouse	$22.46
Employee + Child(ren)	$22.92
Family	$36.96

LIFE AND DISABILITY COVERAGE MADISON NATIONAL

BASIC LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) PLAN

The Basic Life and AD&D plan provides a $25,000 benefit in the event of your death, dismemberment or paralysis. This benefit is covered by Crawford County, so you will automatically be enrolled at no cost to you.

SUPPLEMENTAL LIFE INSURANCE

You may purchase additional life insurance at group rates:

- Available in increments of $10,000 up to $300,000. You pay the full cost of this plan and the amount deducted depends on your age and the amount of coverage elected.
- If you do not elect this coverage when first becoming eligible or an election over 100,000 you are subject to medical underwriting.

SPOUSAL AND CHILD LIFE INSURANCE

You may purchase additional dependent life insurance at group rates:

- Spousal life is available up to $150,000 (not to exceed 50% of Employee Supplemental Life amount)
  - Guarantee Issue is $25,000.
- Child life is available up to $10,000 increments of $5,000
  - The cost remains the same regardless of the number of children you have

SUPPLEMENTAL LIFE RATES

Age	Rate per $1000
18-24	$ .05
25-29	$ .06
30-34	$ .08
35-39	$ .09
40-44	$ .12
45-49	$ .20
50-54	$ .30
55-59	$ .51
60-64	$ .68
65-59	$1.27

LONG-TERM DISABILITY (LTD) PLAN

LTD is provided by Crawford County at no cost to you. If you become disabled for more than 180 days, you may receive a benefit equal to 66.67% of your pre-disability earning up to $6,000 per month.

Remember to review your beneficiaries!

GUARANTEED ISSUE AND EVIDENCE OF INSURABILITY

Employees and spouses who elect Voluntary Life and AD&D coverage when they are first eligible can elect up to the Guaranteed Issue (GI) amount without Evidence of Insurability (EOI). If the amount requested is more than GI, you will need to provide EOI before the amount over GI becomes effective.

WELCOME TO IPERS!

Congratulations on your new job! You work for an Iowa Public Employees' Retirement System-covered employer, so you're automatically an IPERS member. IPERS is an agency of the state of Iowa, employing about 100 people in Des Moines. We care about IPERS because we're IPERS members too.

Each pay period, IPERS will receive a small portion of your wages. These contributions are pooled with other members' wages — and contributions from employers — and are invested to pay the benefit you'll receive upon retirement. The best part: IPERS retirement benefits are guaranteed for life. Upon retirement, you will receive a predictable monthly benefit payment for the rest of your life. That's what makes IPERS different from traditional 401(k)-type plans; your retirement benefit will never run out.

YOU'RE IN GOOD COMPANY

400,000+
MEMBERS

2,000+
EMPLOYERS

ONE IN 10
IOWANS IS AN IPERS MEMBER

IPERS HAS THREE MEMBERSHIP GROUPS

Regular members:
These make up 95% of IPERS membership.

Protection Occupations and Sheriffs/Deputy Sheriffs members:
These are two smaller membership groups. Collectively, IPERS refers to these as Special Service members. These members work in public safety occupations.

IPERS

WHAT IS IPERS?

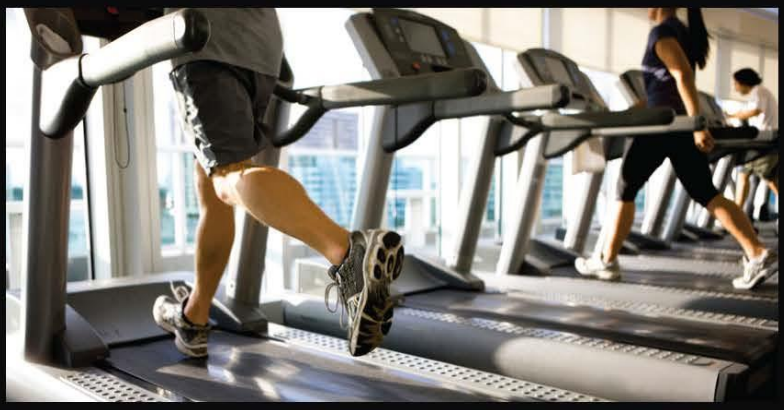
The state's largest public retirement plan, the Iowa Legislature created IPERS in 1953 to attract and retain quality public employees. Today, IPERS is a trust fund of more than $40 billion that pays more than $2 billion in benefits annually. The Iowa Legislature and the Governor are the retirement plan's sponsors, and IPERS is the plan administrator. Federal and state laws regulate the administration of retirement plans for public employees, including IPERS.

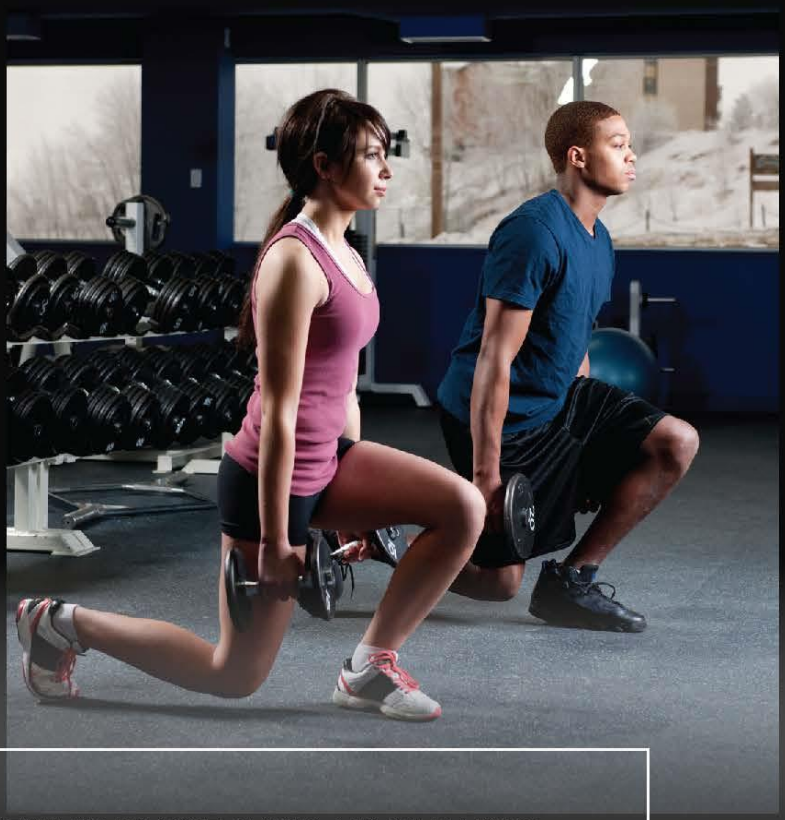
The Iowa Legislature and Governor determine the employment positions that qualify for each membership group and the benefits provided. The benefits for each group are somewhat different and are fully explained in the IPERS Member Handbook. To read the IPERS Member Handbook, visit our website at www.ipers.org/publications.

CRAWFORD COUNTY EMPLOYEE

MEMBERSHIP DISCOUNT

The Fit Behaviour
For every body.





WHY JOIN?

INVEST IN YOURSELF AND ACHIEVE YOUR FITNESS GOALS WITH EFFECTIVE GYM MEMBERSHIP. UNLOCK YOUR FITNESS POTENTIAL AND GET FIT TOGETHER WITH THE FIT BEHAVIOUR

BENEFITS:

- CONVIENTLY LOCATED IN UPTOWN DENISON
- 24 HOUR ACCESS
- FITNESS PLANNER
- PERSONAL TRAINING AVAILABLE
- MODERN EQUIPMENT
- PAYROLL DEDUCTION AVAILABLE

MONTHLY MEMBERSHIP

$15* /PERSON

*PLUS TAX

GET MOTIVATED, AND STAY ENERGIZED! SIGN UP TODAY!

→

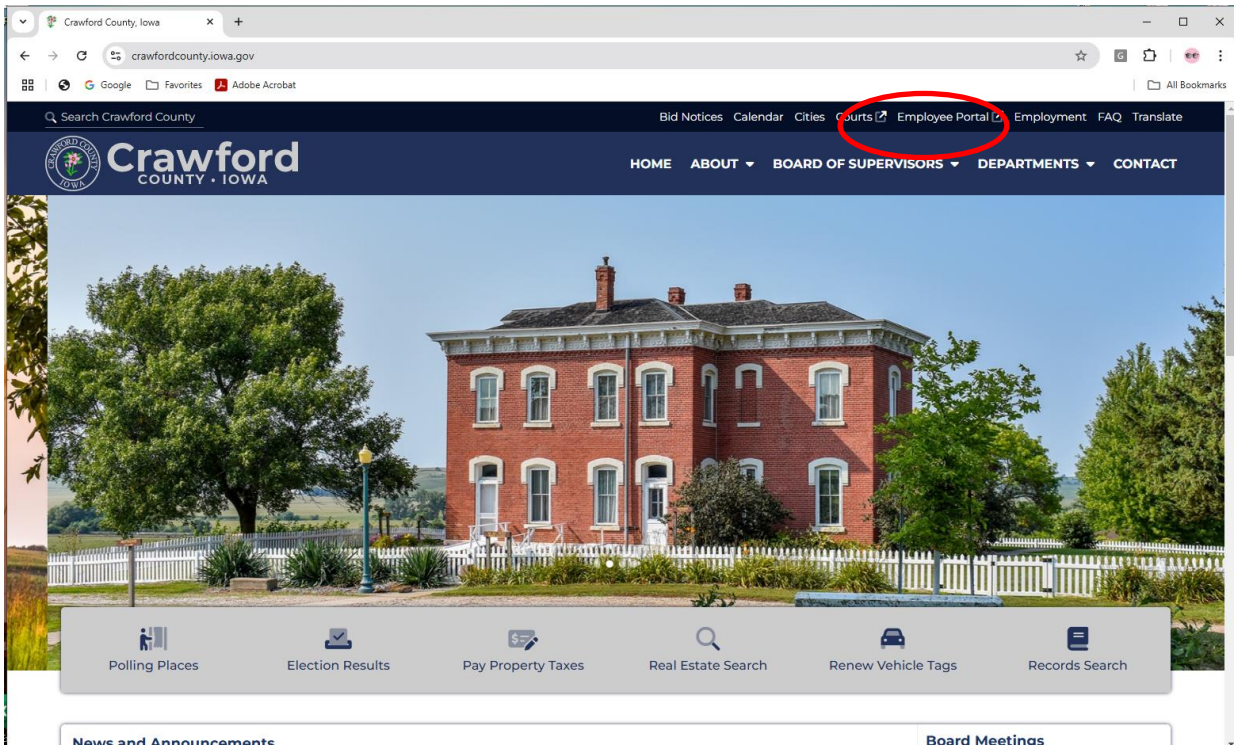
CONTACT ADRIENNE AT 712.269.2477

IMPORTANT CONTACTS

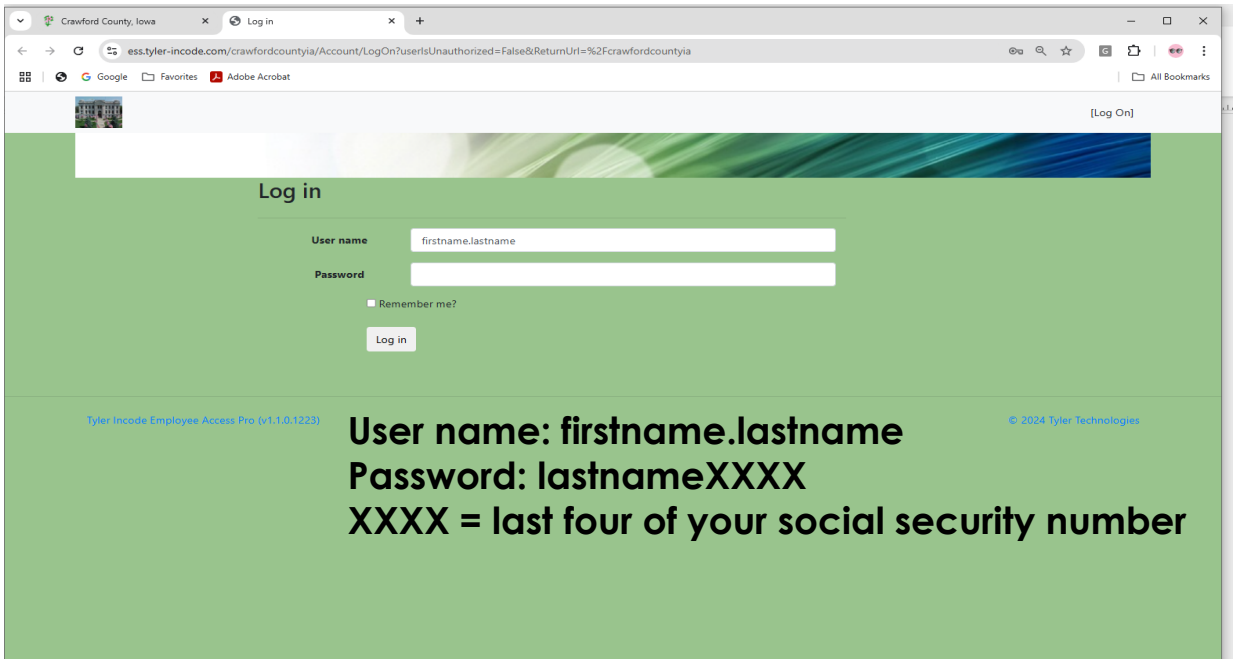
Coverage	Contact	Phone	Website
Medical	Wellmark	800-524-9242	www.wekka.com
Flexible Spending Account	TASC	888-595-2261	www.tasconline.com
Dental	Delta Dental	800-544-0718	www.deltadentaia.com
Vision	VSP	800-877-7195	www.vsp.com
Life and AD&D	NIS	800-627-3660	www.nisbenefits.com
Disability	NIS	800-627-3660	www.nisbenefits.com
Employee Assistance Program	NIS	800-627-3660	www.nisbenefits.com

HR/Payroll
Amy Pieper 712-263-2416 or
apieper@crawfordcounty.iowa.gov

Online Employee Portal



To access your online employee portal go to the county website: www.crawfordcounty.iowa.gov
Click on "Employee Portal" (circled)



Please wait a week after returning your completed new hire packet to the Auditor's office to access the portal.

Wellmark

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

Group Employee Application for Health Insurance

Wellmark Blue Cross and Blue Shield of Iowa
updatesgroupmembership@wellmark.com

Failure to fill out this application completely may result in a delay of coverage.

Effective Date _____/_____/_____

☐ Special Enrollee ☐ Change ☐ Open Enrollment Period ☐ Newly Eligible

A. Employer Information (Completed by Employer)

Employer Name_____

Employer Group Number_____

Employer Subgroup_____

B. Employee Information

Name (First, MI, Last)_____

Address Line 1 (Street Address or Suite#)_____

Address Line 2 (PO Box, Street Address)_____

City_____ State_____ ZIP_____

Home Phone Number (_____)_____ Cell Phone Number (_____)_____

Email Address_____

Date of Birth _____/_____/_____ (mm/dd/yyyy) Gender: ☐ Male ☐ Female Status: ☐ Single ☐ Married

Social Security Number/Tax Identification Number _____

(Social Security Number (SSN) or Tax Identification Number (TIN) must be provided.)

Date of Hire (required)_____/_____/_____ (mm/dd/yyyy)

Employment Status: ☐ Full-Time ☐ Part-Time ☐ COBRA ☐ Retiree ☐ Seasonal

Health: ☐ Employee ☐ Employee/spouse ☐ Employee/child(ren) ☐ Employee/spouse/child(ren)

Health Product ID* _____ ☐ **Not Elected**

*If you're enrolling in an HMO/WHPI plan a Primary Care Provider (PCP) must be elected for each family member. Please visit www.myWellmark.com to select your PCP.

As a Wellmark contract holder, you will receive a Summary of Benefits and Coverage (SBC) that outlines important information about your coverage. You can also access Wellmark.com/Inform to help you make the best decisions for you and your family. This site includes important information on your prescription drug coverage, like the accessibility and availability of prescription drugs, how to request a current drug list and the process for requesting an exception to the drug list. You also can find a list of participating providers and facilities, and how to obtain a prior authorization. For more information, or if you have any questions, you can call the Wellmark Customer Service number located on the back of your ID card.

C. Enrollment Reason or Event

Special Enrollment Event Reason:

☐ Birth
☐ Marriage
☐ Divorce
☐ Adoption or placement for adoption
☐ Court-ordered coverage
☐ Other _____
☐ Legal guardianship
☐ Foster child placement
☐ Involuntary loss of creditable coverage
☐ Permanent move to Iowa
☐ Returning from military service

List date of special enrollment event _____/_____/_____ (mm/dd/yyyy) (or last day of coverage)

Employee Name (First, Last)	Social Security Number / Tax Identification Number

D. Members/enrollees Covered

If you need to list more than four dependents, please write all necessary information on a separate sheet of paper and attach to this application. Your employer determines eligibility for coverage. Please confirm with your employer that the dependent types listed below are eligible.

Name (First, MI, Last)		Date of Birth (mm/dd/yyyy)	Social Security Number/Tax Identification Number[1]	Gender	FT Student?[2]	Disabled?[2]
☐ Spouse		/ /	a. ☐ SSN/TIN ____ b. ☐ Does not have an SSN/TIN	☐ Male ☐ Female	N/A	☐ Yes
☐ Dependent		/ /	a. ☐ SSN/TIN ____ b. ☐ Does not have an SSN/TIN	☐ Male ☐ Female	☐ Yes	☐ Yes
☐ Dependent		/ /	a. ☐ SSN/TIN ____ b. ☐ Does not have an SSN/TIN	☐ Male ☐ Female	☐ Yes	☐ Yes
☐ Dependent		/ /	a. ☐ SSN/TIN ____ b. ☐ Does not have an SSN/TIN	☐ Male ☐ Female	☐ Yes	☐ Yes
☐ Dependent		/ /	a. ☐ SSN/TIN ____ b. ☐ Does not have an SSN/TIN	☐ Male ☐ Female	☐ Yes	☐ Yes

[1]The IRS requires Wellmark to collect SSNs/TINs for federal reporting purposes. Your employer will follow up with you to collect this information if you do not complete a. or b. for each person listed. Failure to provide the SSN/TIN information may result in a monetary penalty, per violation, assessed to you by the IRS.

[2]If your plan covers dependent(s) age 26 or older, they must be unmarried and either a full-time student or a disabled dependent. Please contact your Wellmark representative for more information.

E. Medicare Coverage (Required)

Are you and/or anyone listed in the Dependent Information section Social Security disabled? ☐ Yes ☐ No

Are you and/or anyone listed in the Dependent Information section enrolled in Medicare? **(Required if Medicare enrolled, absence of a response will be considered as a response of "No")** ☐ Yes ☐ No

If yes, complete as appropriate:

Name[3]	Medicare ID	Effective Dates		
		Part A	Part B	Part D
		/ /	/ /	/ /
		/ /	/ /	/ /

[3]If you need to list more than two members, please write all necessary information on a separate piece of paper and attach to this application.

Employee Name (First, Last)	Social Security Number / Tax Identification Number

F. Other Health Coverage Information (Required)

☐ Yes ☐ No Will you, your spouse, or your dependents keep other health coverage in addition to this Wellmark, Inc. coverage?

If yes, please complete the following:

Policyholder Name (First and Last)_____

Please list those covered by the other health plan(s)_____

Policy Number_____ Effective Date _____/_____/_____

Insurance Company/HMO Name_____

Is there a divorce decree/court order that requires one parent to provide health insurance coverage for any dependent?

☐ Yes ☐ No If yes, please complete the following:

List dependent(s)_____

List name of person required to provide health insurance_____

List name of person who has primary physical custody_____

G. Important Information Regarding Waiver Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself or 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 a period of time specified by your employer after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, 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 dependents. However, you must request enrollment within the time specified by your employer after the marriage, birth, adoption, or placement for adoption. Additionally, you must enroll within the time specified by your employer after you lose eligibility for coverage under Medicaid or CHIP or become eligible for Medicaid or CHIP premium assistance.

Please note that if you or your dependents are not covered by minimum essential coverage, you may be responsible for individual shared responsibility payments when filing your federal income tax return. Also, by declining the coverage offered by your employer, you or your dependents may not be eligible for Marketplace coverage subsidies.

To request special enrollment or obtain more information, refer to your Summary Plan Description (SPD), coverage manual, other benefits documents, or contact your employer.

H. Authorization and Certification

I certify that I am legally authorized to apply for coverage for myself and all other persons named in this application. I understand that I am completing this application for the coverage sponsored by my employer or group sponsor and offered by Wellmark, Inc., doing business as Wellmark Blue Cross and Blue Shield of Iowa, or Wellmark Health Plan of Iowa, Inc. (each referenced herein as "Wellmark").

I certify that, after this application was completed, I carefully and fully read it, that the statements and answers set forth are full, true, and correct to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that my employer or group sponsor will rely on the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or concealed any material fact, my employer or group sponsor is entitled to declare the contracts applied for void and to refuse allowance on benefits to any person thereunder. I understand and grant authorization for my employer, group sponsor, consultant, or Wellmark agent to electronically submit the information provided by me on this signed application for enrollment purposes.

I acknowledge I have received or have been advised and understand I will receive from my employer the Summary of Benefits and Coverage (SBC).

Providing Social Security Numbers or Tax Identification Numbers

Wellmark requires Social Security numbers or other tax identification numbers for federal reporting purposes. If Wellmark does not have Social Security or tax identification numbers for each enrollee, Wellmark or my employer may be unable to report and send information needed to complete federal tax returns. If Social Security numbers or tax identification numbers are not provided for all individuals covered, Wellmark or my employer may contact the primary policyholder to obtain the information. If I do not provide the Social Security numbers or tax identification numbers for these purposes, I may be subject to a monetary penalty imposed by the internal revenue service.

Employee Name (First, Last)	Social Security Number / Tax Identification Number

H. Authorization and Certification, cont'd.

HSA Coverage

In the event I have selected a High Deductible Health Plan, I understand that enrolling in such coverage does not guarantee that I am or will be eligible to make contributions to an HSA or that contributions can be made to an HSA on my behalf.

Consent to Contact Me Via Residential Telephone, Cellular Phone, Text and Email Messages

☐ By checking the box and entering my signature on this application, I hereby provide my consent to Wellmark to contact me about Wellmark policy or products and services that may be available to me. Wellmark may provide this information to me using residential telephone, cellular telephone or wireless device, text message or email contact information provided to Wellmark from time to time. If I provide a telephone number for voice calls, I understand that Wellmark may contact me via live or prerecorded calls. I give Wellmark permission to use my personal data (including personally identifiable information) in accordance with Wellmark's privacy policy to determine the types of products and services that may be offered to me. I understand the telephone company or other communications carrier may impose charges for these contacts and that I am not required to give this consent to purchase any goods or services. I understand I may revoke this consent at any time by calling the number located on the back of my Wellmark ID Card.

I understand that I have the right to refuse to sign this authorization, but that Wellmark will then have the right to condition eligibility determination and enrollment on the receipt of this signed authorization.

I authorize the Wellmark agent or agency who is identified with this application or my employer's group application to enter my application information through Wellmark's electronic enrollment process. In the event of any discrepancy between this paper application form and the information entered electronically may be considered the source of records, and I may contact Wellmark to make any changes to my enrollment information. Wellmark authorized agents are required to retain this original paper application for 11 years.

I have read and understand the Important Information Regarding Waiver of Enrollment and Authorization and Certification language on this application and acknowledge receipt of a fully completed copy of this application.

Employee Signature_____ **Date** _____/_____/_____

If applicant is a minor, please sign below.
Parent/Legal Guardian Printed Name:_____

Parent/Legal Guardian Signature:_____ **Date** _____/_____/_____

EMPLOYEE ENROLLMENT FORM
Universal Benefit Account®

Instructions: Please sign, date, and complete each line on the enrollment form. Enter zero (0) where no amount is being elected. **Return the completed and signed form to your employer for processing**.

For Employer to complete where applicable:

Client/Company Name:		TASC ID:	
Employer Class:		Employer Division:	
Participant Plan Effective Date:		First Payroll Date:	

INDIVIDUAL/PARTICIPANT INFORMATION

All fields are required for account setup. Information is confidential and is not used for marketing purposes.

First Name:		MI:		Last Name:	
TASC ID (if known):		Email Address:			
Primary Phone:		Mobile Phone:			
Primary Address:	Address Line 1:			Apt:	
	Address Line 2:				
	City:				
	State:		ZIP/Postal Code:	+4	
Hire Date:		Payroll Frequency:			
Date of Birth (DOB):		Social Security Number:			

ANNUAL ELECTIONS

Prior to completing your election amounts below, please refer to the instructions on page 2.

I select the following benefits and amount(s) to be deducted pretax:		Employee Annual Election Amount	Employee Per Pay Period Contribution	Maximum Employee Annual Election
☐	**Healthcare FSA** ☐ I elect to exclude my spouse (for HSA eligibility reasons)	$	$	$
☐	**Limited Purpose Healthcare FSA**	$	$	$
☐	**Dependent Care FSA** **(Daycare Expenses)**	$	$	$
☐	**Health Savings Account (HSA)**	$	$	$ *Single* / *Family*
	Indicate HDHP Coverage Level *(select one)*:		☐ **Self-Only** ☐ **Family/Other**	
	Indicate if you are enrolled in an HDHP through your employer:		☐ **Yes** ☐ **No**	

TASC CARD

You will receive one TASC Card to use for your benefit account(s). You may request **one additional card** for your spouse or dependent free of charge. Cards are mailed to your home address 7-10 days after your enrollment has been processed.

To request an additional TASC Card for your spouse or dependent, print their name below (or request via TASC web portal):

1	**Spouse or Dependent Name (First, MI, Last):** **(No fee)**	
2	**Dependent Name (First, MI, Last):** **(Additional fee may apply)**	
3	**Dependent Name (First, MI, Last):** **(Additional fee may apply)**	

PLOYEE ENROLLMENT FORM

Universal Benefit Account®

AUTHORIZATION

I certify the above information to be true to the best of my knowledge and that the children for whom I will be claiming dependent or child care expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I agree to have my compensation reduced by the deduction amount(s) stated above. I understand amounts remaining in my flexible spending account(s) not used for qualified expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand that the FSA deduction(s) will be in effect for the entire plan year and cannot be changed or revoked except as permitted by federal law. I understand that my share of eligible group premium(s) will be automatically deducted before taxes. I also understand that if I do not wish to have my eligible insurance contributions deducted pretax and prefer to be taxed on these dollars, I will contact my payroll department. I understand additional TASC Cards issued to my spouse or dependent will provide the named individual with access to my flexible spending account(s) and MyCash account. I accept all responsibility for card transactions incurred by the named individual and will submit supporting documentation, as requested, for those transactions. I agree that upon inappropriate or fraudulent use of the TASC Card or termination of employment, I will immediately return all TASC Cards to my Employer.

Signature: _____ Date: _____

☐ ***(HSA Only)*** **I am enrolling in an HSA through my employer. I authorize my employer to deduct my HSA contributions from my pay and forward them to my HSA. By signing I am agreeing to terms and conditions on the CUSTODIAL AGREEMENT AND DISCLOSURE STATEMENT and DESIGNATION OF REPRESENTATIVE BY ACCOUNTHOLDER.**

ELECTION INSTRUCTIONS

Instructions for entering elections under each applicable benefit account type:

1. **Healthcare FSA Election:** The amount you expect to pay out-of-pocket toward eligible medical expenses throughout the plan year, which may include deductible and co-insurance portions of health insurance (NOT premiums), dental, orthodontic, and eye care expenses. Participants may elect a maximum based on the current IRS limits. Your employer's plan maximum may be less than the IRS maximum. Review your Summary Plan Description (SPD) for your specific plan maximum. Your election will be split into equal amounts to be deducted pretax from every payroll throughout the plan year. Your total annual election amount is available for reimbursement of eligible expenses on the first day of the plan year.
2. **Limited Purpose Healthcare FSA Election:** Amount you expect to pay out-of-pocket for dental and vision expenses throughout the plan year. Your total election amount is available on the first day of the plan year as expenses are incurred. Refer to your SPD for your specific plan maximum.
3. **Dependent Care FSA Election:** Amount you expect to pay out-of-pocket for eligible day care expenses for the Plan Year. The maximum allowable amount under IRS regulations is $5,000 per calendar year per family; $2,500 per calendar year for married individuals filing single. Plan funds are available as they are contributed.
4. **Health Savings Account Election:** Your contributions will be withdrawn from your pay in each pay period. If your employer maintains a cafeteria plan that permits HSA contributions, your contributions will be made with pre-tax dollars. You may also make contributions outside of your employment. If you would like to make a contribution immediately, please go to your employee web portal to do so. Your employer may also make a contribution to your HSA that will apply to your maximum contribution allowed. You are solely responsible for determining whether contributions to an HSA exceed the maximum annual contribution limitation. You are also responsible for notifying the custodian of any excess contribution and requesting a withdrawal of the excess contribution together with any net income attributable to the excess contribution.

IMPORTANT NOTE! How Cafeteria Plans affect Social Security Benefits: Reduction of your Social Security benefits will be minimal and is offset by the tax savings and lower healthcare costs available under an FSA. To compensate for this minimal reduction, you may consider increasing your retirement plan funding.

For enrollment assistance, call toll-free 1-800-422-4661.
Have your enrollment form, employer name, and the Client ID ready.
Find all IRS limits on our resource web page: www.tasconline.com/benefits-limits

DELTA DENTAL

Large Employer Group Enrollment/Change Form

☐ New Applicant ☐ Change of Coverage ☐ Name/Address Change

Employer Choice

(Completed by Employer)

Group Number _____ Effective Date ___/___/___ Department/EE Number _____

1 POLICYHOLDER INFORMATION

Name (First, Middle Initial, Last) _____ Social Security Number _____

Mailing Address _____ City _____ State _____ Zip _____ Status ☐ Single ☐ Married ☐ Other (specify) _____ Hire Date ___/___/___

Telephone (___) _____ ☐ Home ☐ Cell Phone Email Address _____

Employer Name _____ Employer Location _____

2 ELIGIBLE MEMBERS ELECTING COVERAGE

List self & eligible members to be covered First Name MI Last (if different)	Social Security Number	Birthdate	Sex	Full-Time College Student	Disabled Status	Other Dental Coverage
Self		___/___/___	☐ M ☐ F		☐ Yes ☐ No	☐ No ☐ Yes
Spouse		___/___/___	☐ M ☐ F		☐ Yes ☐ No	☐ No ☐ Yes
Eligible Child		___/___/___	☐ M ☐ F	☐ Yes ☐ No School Name:	☐ Yes ☐ No	☐ No ☐ Yes
Eligible Child		___/___/___	☐ M ☐ F	☐ Yes ☐ No School Name:	☐ Yes ☐ No	☐ No ☐ Yes
Eligible Child		___/___/___	☐ M ☐ F	☐ Yes ☐ No School Name:	☐ Yes ☐ No	☐ No ☐ Yes

Other Dental Coverage – if any person(s) on this application has other dental insurance please complete.

Policyholder _____

Name of Other Dental Carrier(s) _____ Policy Number _____ Effective Date ___/___/___ Contract Type ☐ Single ☐ Family

3 CHANGE OF COVERAGE

Please check events requiring Contract changes:

☐ Marriage ☐ Death ☐ Divorce ☐ Birth/Adoption ☐ Drop Covered Person ☐ COBRA ☐ Terminating Benefits ☐ Part-Time to Full-Time

☐ Other (explain) _____ Name of Affected Party _____ Date of Event ___/___/___

4 AGREEMENT AND CERTIFICATION

I have read and understand the Agreement and Certification and/or Waiver of Coverage language on the back of this application and acknowledge receipt of a fully completed copy of this application.

ACCEPTANCE/WAIVER OF COVERAGE

☐ I accept the dental coverage selected above.

☐ I waive dental coverage for my family members and/or myself. (Please indicate reason) _____

X _____ ___/___/___

Employee Signature Date

TeamService@deltadentalia.com • www.deltadentalia.com • Fax: 1-888-558-9212 • Phone: 1-877-983-3582

(Over, please)

AGREEMENT AND CERTIFICATION

I certify I am legally authorized to apply for coverage for myself and/or for all other persons named in this application. I understand I am applying for coverage sponsored by my employer or Plan Sponsor offered by Delta Dental of Iowa ("Delta Dental"). I authorize my employer, to deduct from my pay or collect from me in advance the premium therefore and remit such sums to Delta Dental on my behalf. This authorization is to remain in effect until I, or my employer or Plan Sponsor, notifies Delta Dental to the contrary. I understand coverage for the dental policy applied for will not start until after this application and the monies for the first month's premium are deducted from my pay or paid to my employer, and are received and accepted by Delta Dental. I further understand that Delta Dental establishes the effective date of the policy. I also understand the amounts are subject to change at least annually and my employer or Plan Sponsor will furnish written notice of such changes to me.

I certify that after this application was completed, I carefully and fully read it, that the statements and answers set forth are full, true, and correct, to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that Delta Dental will rely upon the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or have concealed any material fact, Delta Dental will be entitled to declare the dental and/or vision policy applied for void and refuse allowance of benefits to any person thereunder.

I authorize any health care provider to release medical records to Delta Dental when reasonably related to the dental coverage for which I have applied for. If any law or regulation requires additional authorization for release of dental and/or vision records, I will give this authorization.

WAIVER OF COVERAGE

I understand if I decide not to apply for coverage, or if I apply only for myself even though coverage is available for eligible members of my family, any subsequent application will be subject to the applicable terms and conditions of the Group Insurance Policy to provide dental benefits, which may require additional limitations and waiting periods. I also understand Delta Dental reserves the right to reject such an application.

NONDISCRIMINATION AND ACCESSIBILITY

Delta Dental of Iowa complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. To review our full non-discrimination notice, please go to www.deltadentalia.com/nondiscrimination.

Insurance Benefit Enrollment Form

Employee: Complete and return this form to your Benefits Administrator.

NATIONAL INSURANCE SERVICES

Benefits Administrator: Retain a copy of this form for your records and provide employee with a copy. Mail original to:
National Insurance Services, Attn: Billing Department
250 S. Executive Drive, Suite 300, Brookfield, WI 53005-4273
Phone: 1.800.627.3660 Fax: 262.785.9269

Enter your information:

Employer Name: **Crawford County**			NIS Group Number: **029391**	
Full Name (Last name, First name, Middle Initial):			Date of Hire:	
Home Address:		City:	State:	Zip:
Social Security Number:	☐ Single ☐ Married	U.S. Citizen? ☐ Yes ☐ No*	Date of Birth:	☐ Male ☐ Female
Occupation/Title:	Date Benefit Eligible:		Hours worked per week:	Annual Salary:

*If you are not a U.S. Citizen, please provide a copy of your Visa.

Insurance benefits:

Employer-Provided Insurance Benefits:

☒ **Employee Basic Life and AD&D** Amount $25,000
☒ **Long-Term Disability**

Optional Insurance Benefits (See Rate Table on last page):

☐ Elect	☐ Decline	**Employee Supplemental Life and AD&D** Amount $_____ $10,000 increments to a maximum of $300,000 not to exceed 5 times annual salary. *Evidence of Insurability is required for late enrollees, increases in amounts and amounts over the Guarantee Issue Amounts of $100,000 Employees under age 60, $10,000 Employees age 60-69, $0 Employees age 70 or older.*
☐ Elect	☐ Decline	**Spouse Supplemental Life** Amount $_____ $5,000 increments to a maximum of $150,000 not to exceed 50% of the Employee's Supplemental Life amount. *Evidence of Insurability is needed for late enrollees, increases in amounts and amounts over the Guarantee Issue amounts of $25,000 Spouse under age 60; $5,000 Spouse age 60-69.*
☐ Elect	☐ Decline	**Child Dependent Life** ☐ Option 1: $5,000 Child (age 6 months to age 25) / $500 Infant (age 14 days to 6 months) ☐ Option 2: $10,000 Child (age 6 months to age 25) / $1,000 Infant (age 14 days to 6 months) *Evidence of Insurability is required for late enrollees and increases in amounts.*

Sign here (required whether electing or declining any coverage):

I have been given the opportunity to apply for group insurance and agree to accept or decline coverage(s) as noted above. If I am declining coverage(s), I understand that if my dependents or I decide to apply for coverage at a later date, Evidence of Insurability (medical questions) may be required at my own expense and the insurance company must approve coverage. If I have elected any coverage(s) above, I authorize my employer to make any required deductions, if any, from my salary to pay my portion of the insurance premium when my insurance becomes effective.

Warning: Any person who knowingly presents false information on an application for insurance may be guilty of a crime and subject to fines, confinement in prison, and/or denial of insurance benefits.

Signature:	Date:

More on other side ----------→

Full Name:	Employer Name: **Crawford County**	Date:

Enter your Life Insurance beneficiary information:

Primary Beneficiary(ies) Attach additional pages if necessary.		
Full Name:	Relationship to you:	% of Benefit
Full Name:	Relationship to you:	% of Benefit
Full Name:	Relationship to you:	% of Benefit
		Total % of Benefit must equal 100%

Secondary Beneficiary(ies) Attach additional pages if necessary.		
Full Name:	Relationship to you:	% of Benefit
Full Name:	Relationship to you:	% of Benefit
Full Name:	Relationship to you:	% of Benefit
		Total % of Benefit must equal 100%

Add spouse/dependent information:

Please provide the following information if electing Dependent Coverage**.** Attach additional pages if necessary.

Full Name		**Date of Birth**	**Social Security #**	**Full-Time Student?**
Spouse:	Date of Marriage:			n/a
Child:				☐Yes ☐No
Child:				☐Yes ☐No
Child:				☐Yes ☐No
Child:				☐Yes ☐No
Child:				☐Yes ☐No

Sign here:

Signature:	Date:

Full Name:	Employer Name: **Crawford County**	Date:

Rate Table and Monthly Cost:

Employee and Spouse Supplemental Life Age Rates

Spouse rates are based on Spouse's Age

Age	Rate per $1,000 of coverage
Under 25	$0.05
25-29	$0.06
30-34	$0.08
35-39	$0.09
40-44	$0.12
45-49	$0.20
50-54	$0.30
55-59	$0.51
60-64	$0.68
65-69	$1.27
70-74	$2.06
75-79	$3.56
80-99	$5.37

Add $0.03 per $1,000 for Employee AD&D

To calculate your monthly premium:

_____ / $1,000 = _____ x _____ = $_____

Coverage Amount Rate (See chart) Total Monthly Premium

Child Dependent Life Monthly Premium

$0.87 per dependent unit Option 1 $5,000

$1.74 per dependent unit Option 2 $10,000

Page left blank intentionally

Enrollment Form with Dependent Data

Name of group (employer): _____

Employee last name, first name, middle initial: _____

Social Security Number: _____

Effective Date: _____

Gender: ☐ male ☐ female

Date of birth (month/date/year): _____

Type of coverage selected:

☐ employee only
☐ employee and one dependent
☐ employee and children
☐ employee and family
☐ waive coverage

*** Dependent Relationship**: S=spouse, C=child, H=handicapped child, T=student

dependent last name	dependent first name	gender	* Dependent Relationship ☐ ☐ ☐ ☐	date of birth mm/dd/yy yy
			☐ S ☐ C ☐ H ☐ T	/ /
			☐ S ☐ C ☐ H ☐ T	/ /
			☐ S ☐ C ☐ H ☐ T	/ /
			☐ S ☐ C ☐ H ☐ T	/ /
			☐ S ☐ C ☐ H ☐ T	/ /
			☐ S ☐ C ☐ H ☐ T	/ /
			S C H T	/ /

Employee Signature: _____

Please return this form to your benefits administrator. Do not return to VSP.

CHIP NOTICE

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 Crawford County, 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 on the following page, 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, dial **1-877-KIDS NOW**, or visit **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, 2024. Contact your State for more information on eligibility.

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

State	Website/E-mail	Phone
Alabama (Medicaid)	**http://www.myalhipp.com/**	1-855-692-5447
Alaska (Medicaid)	*Premium Payment Program:* **http://myakhipp.com/** *Medicaid Eligibility:* **https://health.alaska.gov/dpa/Pages/default.aspx** *E-mail:* **CustomerService@MyAKHIPP.com**	1-866-251-4861
Arkansas (Medicaid)	**http://myarhipp.com/**	1-855-692-7447
California (Medicaid)	**http://dhcs.ca.gov/hipp** **hipp@dhcs.ca.gov**	916-445-8322 916-440-5676 (fax)
Colorado (Medicaid and CHIP)	*Medicaid:* **https://www.healthfirstcolorado.com/** *CHIP:* **https://hcpf.colorado.gov/child-health-plan-plus** *HIBI:* **https://www.mycohibi.com/**	1-800-221-3943 1-800-359-1991 1-855-692-6442 State relay 711
Florida (Medicaid)	**https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html**	1-877-357-3268

State	Website/E-mail	Phone
Georgia (Medicaid)	*HIPP:* https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp *CHIPRA:* https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra	678-564-1162, press 1 678-564-1162, press 2
Indiana (Medicaid)	*Healthy Indiana Plan for low-income adults 19-64:* http://www.in.gov/fssa/hip/ *All other Medicaid:* https://www.in.gov/medicaid	1-877-438-4479 1-800-457-4584
Iowa (Medicaid and CHIP)	*Medicaid:* https://dhs.iowa.gov/ime/members *CHIP:* http://dhs.iowa.gov/Hawki *HIPP:* https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp	1-800-338-8366 1-800-257-8563 1-888-346-9562
Kansas (Medicaid)	https://www.kancare.ks.gov/	1-800-967-4660 HIPP: 1-800-967-4660
Kentucky (Medicaid and CHIP)	*Medicaid:* https://chfs.ky.gov/agencies/dms *KI-HIPP:* https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx *KI-HIPP E-mail:* KIHIPP.PROGRAM@ky.gov *KCHIP:* https://kynect.ly.gov	1-855-459-6328 1-877-524-4718
Louisiana (Medicaid)	www.medicaid.la.gov www.ldh.la.gov/lahipp	1-888-342-6207 1-855-618-5488
Maine (Medicaid)	https://www.maine.gov/dhhs/ofi/applications-forms https://www.mymaineconnection.gov/benefits/s/?language=e_n_US	*Enroll:* 1-800-442-6003 *Private HIP:* 1-800-977-6740 TTY: Maine relay 711
Massachusetts (Medicaid and CHIP)	https://www.mass.gov/masshealth/pa **Email:** masspremassistance@accenture.com	1-800-862-4840 TTY: 711
Minnesota (Medicaid)	https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp	1-800-657-3739
Missouri (Medicaid)	http://www.dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
Montana (Medicaid)	http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP HHSHIPPProgram@mt.gov	1-800-694-3084
Nebraska (Medicaid)	http://www.ACCESSNebraska.ne.gov	1-855-632-7633 *Lincoln:* 402-473-7000 *Omaha:* 402-595-1178
Nevada (Medicaid)	http://dhcfp.nv.gov/	1-800-992-0900
New Hampshire (Medicaid)	https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program	603-271-5218 or 1-800-852-3345, ext. 5218
New Jersey (Medicaid and CHIP)	*Medicaid:* http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ *CHIP:* http://www.njfamilycare.org/index.html	*Medicaid:* 609-631-2392 *CHIP:* 1-800-701-0710
New York (Medicaid)	https://www.health.ny.gov/health_care/medicaid/	1-800-541-2831
North Carolina (Medicaid)	https://medicaid.ncdhhs.gov/	919-855-4100
North Dakota (Medicaid)	https://www.hhs.nd.gov/healthcare	1-844-854-4825
Oklahoma (Medicaid and CHIP)	http://www.insureoklahoma.org	1-888-365-3742
Oregon (Medicaid)	http://healthcare.oregon.gov/Pages/index.aspx	1-800-699-9075
Pennsylvania (Medicaid and CHIP)	Medicaid: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx *CHIP:* https://www.dhs.pa.gov/chip/pages/chip.aspx	*Medicaid:* 1-800-692-7462 *CHIP:* 1-800-986-KIDS (5437)
Rhode Island (Medicaid and CHIP)	http://www.eohhs.ri.gov/	1-855-697-4347 or 401-462-0311 (Direct RIte)
South Carolina (Medicaid)	https://www.scdhhs.gov	1-888-549-0820
South Dakota (Medicaid)	http://dss.sd.gov	1-888-828-0059
Texas (Medicaid)	https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program	1-800-440-0493
Utah (Medicaid and CHIP)	*Medicaid:* https://medicaid.utah.gov/ *CHIP:* http://health.utah.gov/chip	1-877-543-7669
Vermont (Medicaid)	https://dvha.vermont.gov/members/medicaid/hipp-program	1-800-250-8427
Virginia (Medicaid and CHIP)	https://coverva.dmas.virginia.gov/learn/premiumassistance/famis-select https://coverva.dmas.virginia.gov/learn/premiumassistance/health-insurance-premium-payment-hipp-programs	1-800-432-5924
Washington (Medicaid)	https://www.hca.wa.gov/	1-800-562-3022
West Virginia (Medicaid)	https://dhhr.wv.gov/bms/ http://mywvhipp.com/	*Medicaid:* 304-558-1700 *CHIP:* 1-855-699-8447
Wisconsin (Medicaid and CHIP)	https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm	1-800-362-3002
Wyoming (Medicaid)	https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/	1-800-251-1269

IMPORTANT NOTICE FROM Crawford County 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 Crawford County 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 if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Crawford County has determined that the prescription drug coverage offered by the Wellmark Blue Cross Blue Shield plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and 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 Crawford County coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drug. 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 Crawford County coverage, be aware that you and your dependents may be able to get this coverage back, as long as you are an eligible active full time employee.

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 Crawford County 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 Crawford County 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" handbook for 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:	07/01/2024
Name of Entity/Sender:	Crawford County
Contact--Position/Office:	Terri Martens Board of Supervisors
Address:	1202 Broadway Denison, IA 51442 United States
Phone Number:	712-263-3045

HIPAA SPECIAL ENROLLMENT NOTICE

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage (including Medicaid and State Child Health Coverage)
If you are declining coverage for yourself or your dependents (including spouse) because of other health insurance or group health plan coverage, 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 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). Some plans may allow longer than 30 days, so please refer to your plan documents for your specific plan details.

> Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this health plan.

Marriage, Birth, or 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 dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption. Some plans may allow longer than 30 days, so please refer to your plan documents for your specific plan details.

> Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or State Child Health Coverage
If you or your dependents lose eligibility for coverage under Medicaid or State Child Health Coverage Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP or the determination of eligibility for a premium assistance subsidy.

> Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

WOMEN'S HEALTH & CANCER RIGHTS ACT OF 1998

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 consultations with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles, copays and coinsurance applicable to other medical and surgical benefits provided under your medical plan. For more information on WHCRA benefits, contact the [company entity] or your medical plan administrator.

NEWBORNS' AND MOTHER'S HEALTH PROTECTION ACT

For maternity hospital stays, in accordance with federal law, the Plan does not 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 delivery.

However, federal law generally does not prevent the mother's or newborn's attending care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). The plan cannot require a provider to prescribe a length of stay any shorter than 48 hours (or 96 hours following a Cesarean delivery).

PRIVACY NOTICE

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.

YOUR RIGHTS
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records
You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.

We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records
You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.

We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

We will consider all reasonable requests and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share
You can ask us not to use or share certain health information for treatment, payment, or our operations.

We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information
You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
You can complain if you feel we have violated your rights by contacting us using the information on page 1.

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Typically, you can enroll in a Marketplace health plan during the Marketplace's annual Open Enrollment period or if you experience a qualifying life event.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

General Notice of COBRA Continuation Coverage Rights

** 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 [choose and enter appropriate information: must pay or aren't required to 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."

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;
- 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 Crawford County's Resources Department

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 period[1] 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.

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

Crawford County
(712) 263-1280
1202 Broadway
Denison, IA 51442

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

Crawford
COUNTY • IOWA