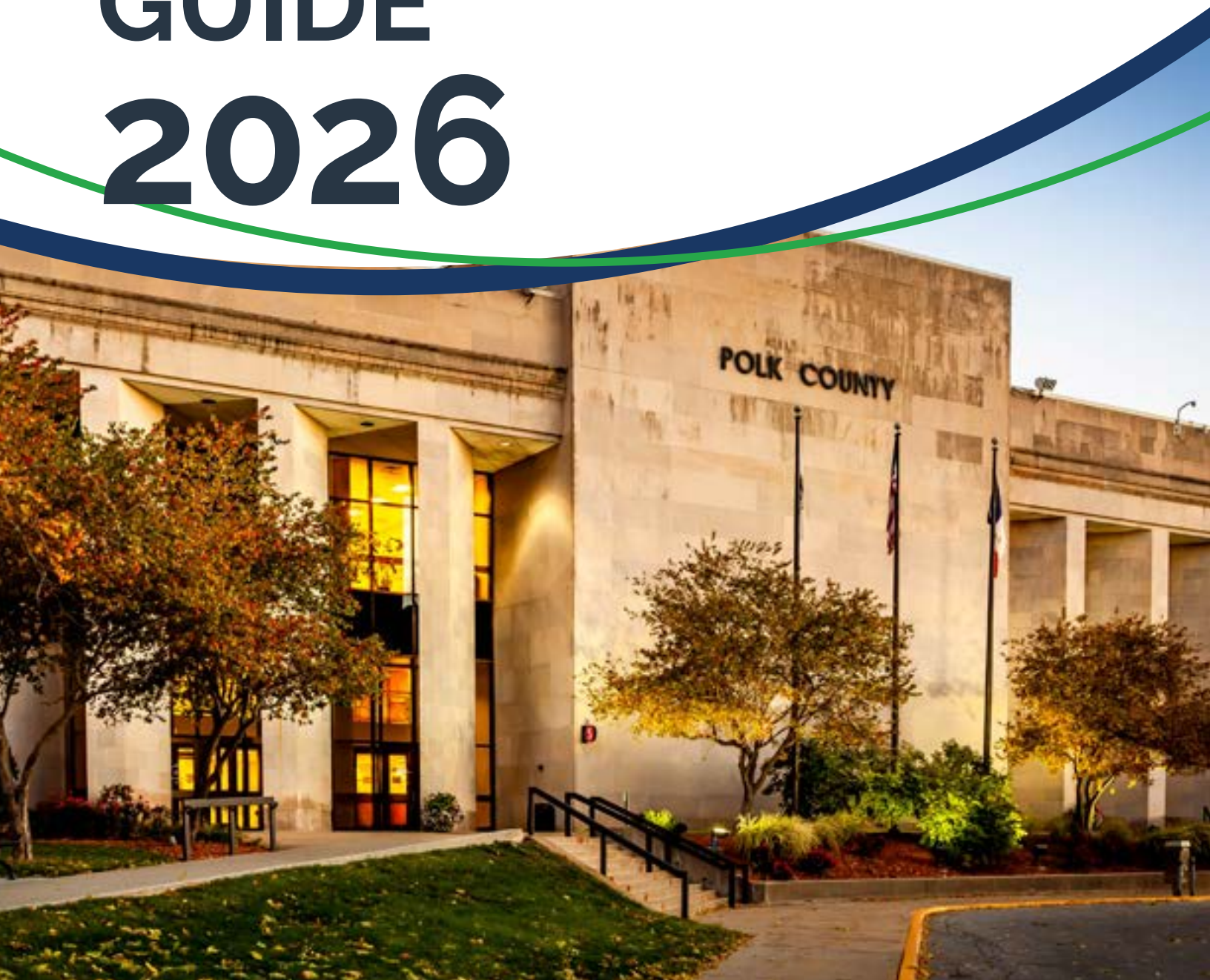
POLK COUNTY
Leading the Way

BENEFITS GUIDE 2026



WHAT'S INSIDE

This is your guide to understanding, selecting, and using the benefits available to you and your family.

Providing great benefit choices to you and your family is just one of the many ways Polk County supports the physical, financial, and emotional wellbeing of our employees.

The intent of this benefit guide is to briefly highlight your benefits and NOT to replace your insurance contracts or booklets. The information has been compiled into summary form to outline the benefits offered by Polk County.

If this benefit summary does not address your specific benefit questions, please refer to the contact page of this booklet. This page will provide you with the information you need to contact the specific insurance carriers and/or your Human Resources Department for additional assistance.

This information provided in this guide is for comparative purposes only. Actual claims paid are subject to the specific terms and conditions of each contract. This benefit guide does not constitute a contract.

HOW TO ENROLL

How to Enroll

Sign into the employee dashboard using your County login credentials (username and password) to access your enrollment options.

Who Can Enroll?

- Full-time employees
- Part-time employees (30+ hours/week)
- Part-time employees (30+ hours/week)

Coverage Effective Date

For new employees, the effective date of coverage varies between date of hire, first of the month following date of hire, or first of the month following 30 days of employment. A complete listing of effective dates can be found on page 15.

Enrollment Deadline

Please make sure to enroll within 31 days from your date of hire. If you don't enroll within this time period, you will not have benefits coverage, except for plans and programs that are fully paid by Polk County unless you experience a Qualifying Life Event.

Qualifying Life Events

After enrollment, you will not be able to make changes to your benefits until the next Open Enrollment, unless you experience a Qualifying Life Event (QLE), such as marriage, divorce, birth, or a change in your spouse's employment. If you do experience a QLE, you will have 31 days to provide appropriate documentation to HR and adjust your benefits.

Confirm Dependent Eligibility

Please verify the dependents you enroll in benefits are eligible for coverage. Dependents who are eligible for medical, dental, vision, dependent life, and voluntary plans include your:

- Legally married spouse or common-law spouse.
- Biological, legally adopted (or placed for adoption) and stepchildren under age 26.
- Children aged 26 or older who are physically or mentally unable to care for themselves and were incapacitated before age 26.
- Unmarried children aged 26 or older who are enrolled as a full-time student. Please notify HR as additional paperwork is required.

- You may need to provide proof of eligibility for your dependents such as a copy of a birth certificate, marriage license, court orders, or any other qualifying legal document.
- To enroll a common-law spouse you must complete the affidavit of marriage available by contacting Human Resources.

Duplicate Coverage

Employees cannot be covered as both an employee or retiree and a dependent under the County's health, dental, and/or vision insurance plans. You, your spouse, and dependents cannot be covered under two county policies.

- Each spouse/dependent may enroll separately in single coverage.
- One member may elect singe coverage and the other member may enroll themselves and dependent(s) in family coverage.
- The member selecting single coverage may not be listed as a dependent on the family plan. One member may elect to waive coverage and the other member may enroll both spouses and dependent(s) in family coverage.

Have questions about enrollment? Human Resources is here to assist you!

(515) 286-3200

benefits@polkcountyiowa.gov

IMPORTANT REMINDERS

Insurance Cards

- After you submit your benefit elections, you will receive insurance cards for health, dental and vision insurance (if elected) within 2-3 weeks.
- Dependents will not receive individual cards. Cards are issued in the name of the employee only.
- If electing family coverage, you will receive two cards. If additional cards are needed, please contact the insurance carrier directly.

Review and Update Personal Information

It is important to keep your information current throughout the year. Most updates can be made through the Employee Dashboard such as:

- Address and Phone Number
- Emergency Contacts
- Beneficiary Designations

Enrollment Deadline

Please make sure to enroll within 31 days from your date of hire. If you don't enroll within this time period, you will not have benefits coverage, except for plans and programs that are fully paid by Polk County unless you experience a Qualifying Life Event.

Primary Care Physicians (PCP)

While Polk County does not maintain this information, you shoulddesignate PCPs for yourself and all your dependents if you enrollin Polk County's health insurance. To add or change your PCP, you can do so through your personalaccount at myWellmark.com or by calling the Wellmark CustomerService number listed on the back of your ID card.

1095 Insurance Tax Form

If you are eligible for health benefits, you will receive TaxForm 1095 which provides information regarding your healthcare coverage as mandated by the Affordable Care Act.

Help us eliminate paper and enroll to receive your 1095 form electronically!

Simply log into the benefits application system, select the Address & Emergency Contacts page, scroll to the Electronic Opt-In section and change your answer to "Yes".

MEDICAL

Quality health coverage is one of the most valuable benefits you enjoy as a Polk County employee. Our benefits program offers plans to help keep you and your family healthy and also provide important protection in the event of illness or injury.

Medical Plan (Wellmark)

Polk County offers its employees the Blue Choice plan provided by Wellmark. Wellmark of Iowa is the largest health care provider network in the state. Wellmark members enjoy network discounts, coverage of 96% of doctors and 100% of hospitals in Iowa, and access to the nationwide BlueCross BlueShield (BCBS) network.

Features

- Affordable coverage for a wide range of health care services
- Flexibility to see any provider you want, although you will save money when you utilize the Blue Choice network
- Free in-network preventive care, with services such as annual physicals, recommended immunizations, well-child exams, flu shots, and routine cancer screenings covered at 100%
- Prescription drug coverage included in the premium
- Financial protection through annual out-of-pocket maximums that limit the amount you will pay each year.

Pharmacy

Along with our health plan, Wellmark administers the County's pharmacy benefits. This means you get comprehensive prescription drug coverage. And, it means all your medical and pharmacy benefits are in one place, making it easier for you to access resources and save money. Pharmacy is included with your health coverage. There is no additional premium or deductible.

Your formulary is a list of the prescription drugs covered by your plan. The purpose of the drug list is to guide you and your doctor to the least costly and most effective medications for treating your health condition. Your plan only pays for medication that are on the Blue Rx Complete drug list. You will pay the full cost if you and your doctor choose a medication that is not included on your plan's drug list.

PLAN SUMMARY

Plan Feature	In-Network	Out-of-Network
Deductible *(Calendar Year or Policy Year)*	$500 per person $1,000 (max) per family	$1,000 per person $2,000 (max) per family
Coinsurance	10%	20% or 30% depending on service
Out-of-Pocket Maximum *(Calendar Year or Policy Year)*	$1,000 per person $2,000 (max) per family	$2,000 per person $4,000 (max) per family
Virtual Visits *(with Doctor on Demand)*	$10 copayment	$10 copayment
Office Visit *(Includes Annual Routine Physical, Well Child Care and Immunizations)*	$20 copayment	Deductible, 20% coinsurance
• **Specialist Office Visit** • **Routine Vision Exam** • **Emergency Services** • **Facility Services** • **Outpatient Services**	• $40 copayment • $0 copayment • Deductible, 10% coinsurance • Deductible, 10% coinsurance • Deductible, 10% coinsurance	• Deductible, 20% coinsurance • Not covered • Deductible, 10% coinsurance • Deductible, 30% coinsurance • Deductible, 30% coinsurance
Pharmacy **Tier 1** **Tier 2** **Tier 3** **Tier 4** **Tier 5**	• $5 copay per prescription • $20 copay per prescription • $35 copay per prescription • $50 copay per prescription • $100 copay per prescription	• $5 copay per prescription • $20 copay per prescription • $35 copay per prescription • $50 copay per prescription • $100 copay per prescription
Mental Health, Behavioral Health, or Substance Abuse Services	• Outpatient services - 0% coinsurance • Inpatient services - 10% coinsurance	• Outpatient services - 30% coinsurance • Inpatient services - $300 copay + 30% coinsurance

Summary of Benefits and Coverage (SBC) and Plan Documents

The health section of this guide provides an overview of your medical plan. The SBC summarizes important information about your health coverage options in a standard format to help you understand your cost and plan features.

Plan Documents and Coverage Manuals for all benefits can be found on the Open Enrollment Application system or the Employee Portal.

DENTAL & VISION

Dental Plan (Wellmark Blue Dental)

Taking care of your teeth and gums - including getting regular dental checkups - is vital to your overall wellness. Our dental plan provides you and your family with coverage for typical dental expenses, such as cleanings, X-rays, fillings, and orthodontia.

Our plan also offers an enhanced benefit program, which links medical conditions and dental benefits. This benefit offers additional oral health services to members with covered medical conditions, such as cancer, diabetes, cardiac conditions, kidney failure, periodontal disease, pregnancy, and suppressed immune systems. Employees must enroll to receive these benefits. To enroll or for more information, call Wellmark Blue Dental at 877-333-0164.

Plan Feature	In-Network	Out-of-Network
Annual Deductible (employee only / family)	$15 / $45	$25 / $75
Calendar-year maximum	$1,250 per person	$1,250 per person
Preventive/diagnostic services	Plan pays 100%	Plan pays 100%
Basic services	Plan pays 90%, after deductible	Plan pays 80%, after deductible
Major services	Plan pays 50%, after deductible	Plan pays 50%, after deductible
Orthodontia services	Plan pays 50%, after deductible	Plan pays 50%, after deductible
Orthodontia Maximum	$1,500 lifetime per person	$1,500 lifetime per person

Find a dental provider

1. **On Wellmark.com:**
   Go to the top menu and click Find Care.
   Select Find a provider or facility.
   Choose Individual, family and employer.
   Scroll to Find an Iowa dentist.
   Search using the Blue Dental PPO network. You can filter by location, dentist type, or name.
2. **On myWellmark:**
   Go to Find a Provider.
   In the Resources box, click Find an Iowa dentist.
   A new screen will open where you can search by plan, location, or provider name.

   You can also use myWellmark to view dental claims and benefits.

Vision Plan (Avesis)

Our vision plan is offered through Avesis. Vision coverage allows you to save money on eligible eye care expenses, such as eyeglasses, contact lenses, and more for yourself and your covered dependents.

Reminder: The vision exam is covered by the Wellmark health plan. The vision plan is for materials only.

Plan Feature	In-Network	Out-of-Network
Exam	Not covered	Not covered
Standard Plastic Lenses Single/Bifocal/Trifocal	$10 copay	Reimbursement up to: $25/$40/$55
Frames	$150 allowance* +10% off balance	Reimbursement up to $70%
Contact Lenses Elective Medically Necessary	$150 allowance Plan pays 100%	Reimbursement up to: $120 $200

New Vision Plan Enhancements

- Lens add-ons fully covered, such as polycarbonate lenses, scratch-resistant and anti-reflective coatings, tints, and UV screenings
- Discounts on upgrades like polarized lenses, standard and premium progressives, and more
- Savings on laser vision correction procedures through participating providers

Find a vision provider

In-network vision providers can be found through the Avesis portal.

To search:
Go to Avesis - Find a Provider.
Click Find a Location.
Under Health Plan, select Commercial Vision (at the bottom of the dropdown).
Enter your ZIP code or other search filters.

Note: You do not need to be a member to search for participating vision providers.

You and Polk County share the cost of your medical, dental, and vision benefits. Polk County pays a generous portion of the total cost and you pay the remainder. The amount you pay is deducted from your paycheck on a pre-tax basis. Your specific cost is determined by the plan you choose and the coverage level you select

Health Insurance

Benefit Group	Employee Only Per Pay Period	Employee + Family Per Pay Period
Teamsters	$47.84	$119.60
AFSCME	$39.86	$99.66
Non-Bargaining Includes Elected Officials, Department Heads, Management, Excluded, Conservation & Assessor employees	$39.86	$99.66

Dental Insurance

Benefit Group	Employee Only Per Pay Period	Employee + Family Per Pay Period
Teamsters	$2.00	$5.42
AFSCME	$1.66	$4.52
Non-Bargaining Includes Elected Officials, Department Heads, Management, Excluded, Conservation & Assessor employees	$1.66	$4.52

Accounts Available

Vision Insurance

Benefit Group	Employee Only Per Pay Period	Employee + Family Per Pay Period
Teamsters	$0.22	$0.64
AFSCME	$0.18	$0.52
Non-Bargaining Includes Elected Officials, Department Heads, Management, Excluded, Conservation & Assessor employees	$0.18	$0.52

INSURANCE PREMIUMS

FLEXIBLE SPENDING ACCOUNTS (FSA)

(P&A Group)

Flexible Spending Accounts (FSA) offer you a way to save money on your health care and/or dependent care (daycare) expenses. The money you deposit into the spending accounts is deducted pre-tax from your paycheck in equal amounts 26 times throughout the year. Most people save at least 25% on each dollar that is set aside through the FSA program. Polk County offers you two flexible spending accounts: the Health Care FSA and the Dependent Care FSA.

Important Facts

- You do not need to be enrolled in Polk County's medical plan in order to participate in the FSAs
- You can participate in the Health Care FSA, the Dependent Care FSA, or both
- You cannot enroll or change your FSA election mid-year unless you experience a qualifying life event
- You must re-elect your FSA contribution every year during open enrollment
- P&A Group will send new enrollees a debit card
- To learn more about FSAs and eligible expenses, go to P&A Group's website at www.padmin.com

Plan Carefully!

FSAs are limited use accounts. There is a rollover available for the Health Care FSA, but no rollover for the Dependent Care FSA.

- **Health Care FSA** – If you do not spend all the money in your account as of December 31, 2026, you can roll over up to the IRS limit of $680 to use in the next calendar year. Amounts above the rollover limit are subject to forfeiture.
- **Dependent Care FSA** – All funds must be used by December 31, 2026. You will have 2 ½ months after the end of the plan year to submit receipts for claims incurred prior to December 31, 2026. Any balance not claimed will be forfeited.

Accounts Available

Health Flexible Spending Account
Covers the cost of medical, dental, and vision expenses incurred by you and your eligible dependent(s). Eligible expenses include deductibles, copays, prescriptions, eyeglasses, and dental work. Minimum annual election: $260 | Maximum annual election: $3,400
Dependent Care Assistance Account
Covers the amount you pay to daycare centers, babysitters, after school programs, day camp programs, and eldercare facilities. This account does NOT reimburse medical expenses for your dependent(s). It is for qualified daycare expenses only. Minimum annual election: $260 | Maximum annual election: $7,500

Manage your account

Go to www.padmin.com or download the P&A Group mobile app on the App Store or Google Play to:

- **Manage Your Account:** Submit claims, upload debit card documentation, check your account balance, and order additional Benefit Cards for your eligible dependents.
- **Use Account Tools:** Calculate your anticipated savings with P&A's calculator, view Penny Panda's educational videos, and browse pre-approved discounted FSA expenses at FSA Store.
- **Access P&A Forms:** Enroll in direct deposit, complete a HIPAA request form, get a Letter of Medical Necessity Form, and more.

FINANCIAL

Life and Accident Insurance (The Standard)

As a Polk County employee, you receive company-paid life and accidental death and dismemberment (AD&D) insurance to provide piece of mind and financial security for your family.

- Full-time and benefit eligible part-time employees receive basic life insurance of $30,000.
- Department Heads receive basic life insurance of 1x times your base annual salary (up to $500,000*).

Elected Officials receive basic life insurance of 3x times your base annual salary (up to $250,000).

- Employee basic AD&D** equal to the employee basic life benefit.
- Federal tax law requires Polk County to report the cost of company-paid life insurance in excess of $50,000 as imputed income.

** AD&D benefits are paid in addition to any life insurance if you die in an accident or become seriously injured or physically disabled.

Have You Named a Beneficiary?

Be sure you've selected a beneficiary for all your life and accident insurance policies. The beneficiary will receive the benefit paid by a policy in the event of the policyholder's death. It's important to designate a beneficiary and keep that information up-to-date.

Review your beneficiary for your retirement plans, too.

Life, AD&D, Disability, and Voluntary Premiums:

- Supplemental Life Insurance and Critical Illness premiums are based on age and coverage selected.
- Short-Term Disability insurance premiums are based on age and compensation.
- Accident and Hospital insurance premiums are based on coverage.
- To view your premiums, visit the Benefit Enrollment System by scanning the QR code.

What is AD&D insurance?

Should you lose your life, sight, hearing, speech, or use of your limb(s) in an accident, AD&D provides additional benefits to help keep your family financially secure. AD&D benefits are paid as a percentage of your coverage amount — from 50% to 100% — depending on the type of loss.

Supplemental Life Insurance

Polk County also provides employees with the option to purchase additional life insurance through The Standard. Coverages are available for an employee, spouse, and dependent children.

Employees must obtain life insurance for themselves if they elect supplemental spouse life coverage.

- Employees may elect coverage in multiples of $10,000 up to a maximum of $500,000. Coverage up to $200,000 is available on a guarantee issue basis.
- Employees may also purchase spouse coverage in multiple of $5,000 up to a maximum of $250,000. Coverage up to $50,000 is available on a guarantee issue basis.
- Employees may purchase children life to insure children up to the age of 26 for $10,000 each.
- Employees may purchase family life to insure both a legal spouse and children up to the age of 26 for $10,000 each.

Note: Guarantee issue amounts are only available to new hires and within the initial enrollment period. An EOI will need to be completed and submitted to The Standard for review and approval if electing an amount above the guarantee issue. Underwriting is not required if electing Child or Family coverage.

VOLUNTARY BENEFITS

Disability Insurance

The loss of income due to illness or disability can cause serious financial hardship for your family. Polk County's short-term and long-term disability insurance programs work together to replace a portion of your income when you're unable to work. The disability benefits you receive allow you to continue paying your bills and meeting your financial obligations during this difficult time.

	Short-Term Disability	Long-Term Disability
Who Pays	Employee-paid	Employer Paid
Benefit Provided	Up to 60% of your weekly salary	Up to 60% of your base monthly salary
Maximum benefit payable	$1,000 per week	$10,000 per month
Maximum benefit duration	12 weeks	Until you're no longer considered disabled or you reach 12 months, whichever is first.
Waiting period	0/7 days	90 days

Accident Insurance

Accident insurance helps offset the unexpected medical expenses when life happens. This coverage can help cover costs such as emergency room fees, deductibles, and copayments that can result from a fracture, dislocation, or other covered accidental injury

Critical Illness Insurance

When a serious illness strikes, critical illness insurance can provide a lump-sum benefit to cover out-of-pocket expenses for your treatments that are not covered by your medical plan. You can also use the money to take care of your everyday living expenses, such as housekeeping services, special transportation services, and day care. Benefits are paid directly to you.

Be sure to submit your wellness benefit claim for your health screening test. You can receive $50 for the Critical Illness or $100 for the Accident Plan.

Hospital Indemnity Insurance

A trip to the hospital can be stressful, and so can the bills. Even with a major medical plan, you may still be responsible for copays, deductibles, and other out-of-pocket costs. A hospital indemnity plan provides supplemental payments directly to you for expenses that your medical plan doesn't cover for hospital stays

Learn More

Visit www.mypolkcountybenefits.com or scan the QR code for more information about your benefits.

RETIREMENT SAVINGS

Polk County believes an employee is best served by having retirement income from more than one source. The retirement plans described below are powerful tools to help you reach your retirement goals. As a supplement to other retirement benefits or savings that you have, these plans allow you to save and invest extra money for retirement consistently and automatically. You can participate in both the IPERS and 457(b)/401(a) plans.

IPERS

Eligible employees are automatically enrolled in this defined benefit pension plan. Each pay period, both you and Polk County contribute toward your retirement by sending a percentage of your wages to IPERS. These contributions are pooled with other members' contributions and are invested to pay the benefit you will receive upon retirement. IPERS monthly retirement benefits are guaranteed for your life. Contributions are based on your membership class.

Membership Class	Employee	Employer
Regular	6.29%	9.44%
Protected	6.335%	9.185%
Sheriff & Sheriff Deputies	12.215%	11.965%

Deferred Compensation

The Polk County Deferred Compensation program is designed so participants have two (2) accounts. The 457(b)/401(a) program is your employer-sponsored supplemental retirement savings benefit. Your contributions to the 457, plus the County's match contributions to the 401(a), help supplement your other retirement savings. You choose a payroll deduction amount and decide pre-tax and/or Roth.

Participants enjoy many benefits:

- Ability to borrow on their 457b account
- Immediate vesting in both accounts
- Employee contributions and Employer Match contributed each pay period
- Any earnings on contributions are tax deferred until the money is withdrawn

New 2026 Calendar Year Limits:

Regular contribution increases to $24,500 50+.
Catchup Contributions are $8,000.
Catch-Up Contributions: Employees earning more than $145,000 in 2025 and who utilize the catch-up contribution must contribute on a Roth (after-tax) basis.
Employees under age 50 can contribute up to the regular limit. Employees age 50+ can contribute up to $32,500.

Employer Match

Polk County will match 50% of your contributions up to the stated maximum below:

Benefit Group	Employer Match
AFSCME & Teamsters	Greater of $26.67 per pay period (based on 27 pay dates) or 1% of base annual salary
Non-bargaining	4% of base annual salary
Department Head	10% of base annual salary
Elected Official	6% of base annual salary

Have a Financial Question? Need a Financial Plan?

Schedule a free one-on-one conversation!

As part of Polk County's Retirement Plan offering, employees have access to a Certified Financial Planner at Creative Planning to discuss your retirement account and your complete financial picture-there's no cost and no obligation.

Francis Enright, CFP
(312) 595-6366

EMPLOYEE ASSISTANCE PROGRAM

Employee & Family Resources (EFR)

Polk County, through EFR, is dedicated to helping you and your family manage life's challenges so you can reach your full potential.

Phone-Based Support Unlimited	Call any time you have an issue, concern, or question. You have 24/7 access to masters-level counselors
In-Person or Telehealth Counseling Three sessions	Arrange counseling sessions with a masters-level counselor near your home or work
Togetherall As needed	Join an online community that offers an anonymous space to connect with your peers and access self-help resources
Virtual Life Coaching Three sessions	Unlock your potential and achieve your goals with the expert guidance of a certified life coach
Virtual First Responder Coaching Three sessions	Partner with a trained coach from the first responder community for guidance and support on the unique challenges and circumstances first responders face
Telephonic Financial Consultation One-30 minute consultation per issue	Speak with a financial professional and access a library of financial resources at efr.org/financial
In-Person or Telephonic Legal Consultation One-30 minute consultation per issue	Meet with a licensed attorney and access self-help legal documents at efr.org/legal
Child/Eldercare Resources As needed	Free telephonic consultations and tailored lists of vetted local resources
Identity Theft Resolution Services As needed	Receive assistance with restoring identity and good credit from a highly trained FCRA certified fraud resolution specialist or licenses attorney

When Should You Use the EAP?

Call 800-327-4692 or visit www.efr.org whenever you are experiencing one of life's challenges. Assistance is available 24/7/365.

What Happens When You Call?

A counselor will answer your call. They will collect basic information and help you connect with a masters-level counselor to discuss your concerns or challenges. All calls are strictly confidential subject to legal requirements.

CONTACTS

Benefit Plan	Effective Date	Provider	Phone number	Website
Medical	First of the month after date of hire/eligibility	Wellmark	800-355-2031	www.wellmark.com
Prescription	First of the month after date of hire/eligibility			
Flexible Spending Accounts (FSAs)	First of the month after date of hire/eligibility	P&A Group	716-852-2611	www.padmin.com
Dental	First of the month after date of hire/eligibility	Wellmark Blue Dental	877-333-0164	www.wellmark.com
Vision	First of the month after date of hire/eligibility	Avesis	855-214-6777	www.myavesis.com
Financial Professionals	First of the month after date of hire/eligibility	Creative Planning	312-595-6366	www.creativeplanning.com
Life and AD&D Insurance	First of the month after date of hire/eligibility	The Standard	888-937-4783	www.standard.com
Disability Insurance	First of the month after 30 days of employment	The Standard	888-937-4783	www.standard.com
Voluntary Policies	First of the month after 30 days of employment	Prudential	844-455-1002	www.prudential.com/mybenefits
Retirement Plans	Date of hire/eligibility	IPERS	515-281-0020	www.ipers.org
457b/401a	First of the month after 30 days of employment	Principal	800-547-7754	www.principal.com
Employee Assistance Program (EAP)	Date of hire/eligibility	Employee Family Resources	800-327-4692	www.efr.org

Required Notices

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1 2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is **offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage**. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility.

To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit healthcare.gov/medicaid-chip/getting-medicaid-chip for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Human Resources at 515-286-3200. 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.

1. Indexed annually; see irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
2. An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

Special Enrollment Notice

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

LOSS OF OTHER COVERAGE

If you are declining coverage 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 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 your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage under this Plan 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 Plan.

MARRIAGE, BIRTH OR ADOPTION

If you have a new dependent as a result of a 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.

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 Plan. However, you must apply within 30 days from the date of your marriage.

MEDICAID OR CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance 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 coverage 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 Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

FOR MORE INFORMATION OR ASSISTANCE

To request special enrollment or obtain more information, please contact: Human Resources at 515-286-3200.

Your Information. Your Rights. Our Responsibilities.

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

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

OUR USES AND DISCLOSURES

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

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.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk

to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

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

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.

- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

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

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Important Notice from Polk 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 Polk 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. **Polk County has determined that the prescription drug coverage offered by the health insurance plan is, 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 15 to December 7.

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 coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will be able to get this coverage back.

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 Polk 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 Polk 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: October 1, 2025
Name of Entity/Sender: Polk County
Contact--Position/Office: Human Resources Department
Address: 111 Court Ave. #390, Des Moines, IA 50309
Phone Number: 515-286-3203

Important Information: COBRA Continuation Coverage and other Health Coverage Alternatives

This 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 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 Polk County 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 the qualifying event occurs. You must provide this notice to: Human Resources by calling 515-286-3200

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 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

Human Resources Department of Human resources: 515-286-3200

1.https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start.

Michelle's Law Enrollment Notice

Note: Pursuant to Michelle's Law, you are being provided with the following notice because Polk County group health plan provides dependent coverage beyond age 26 and bases eligibility for such dependent coverage on student status. Please review the following information with respect to your dependent child's rights under the plan in the event student status is lost.

When a dependent child loses student status for purposes of Polk County group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the Polk County group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the Polk County group health plan, whichever is earlier.

In order to be eligible to continue coverage as a dependent during such leave of absence:

The Polk County group health plan must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary.

To obtain additional information, please contact: Polk County Human Resources at 515-286-3200

Women's Health and Cancer Rights Act

ENROLLMENT NOTICE

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: If you would like more information on WHCRA benefits, call your plan administrator at the phone number listed on the back of your Wellmark ID card.

ANNUAL NOTICE

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 515-286-3200 for more information.

Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act (the Newborns' Act) provides protections for mothers and their newborn children relating to the length of their hospital stays following childbirth.

Under the Newborns' Act, group health plans may not restrict benefits for mothers or newborns for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean

section. The 48-hour (or 96-hour) period starts at the time of delivery, unless a woman delivers outside of the hospital. In that case, the period begins at the time of the hospital admission.

The attending provider may decide, after consulting with the mother, to discharge the mother and/or her newborn child earlier. The attending provider cannot receive incentives or disincentives to discharge the mother or her child earlier than 48 hours (or 96 hours).

Even if a plan offers benefits for hospital stays in connection with childbirth, the Newborns' Act only applies to certain coverage. Specifically, it depends on whether coverage is "insured" by an insurance company or HMO or "self-insured" by an employment-based plan. (Check the Summary Plan Description, the document that outlines benefits and rights under the plan, or contact the plan administrator to find out if coverage in connection with childbirth is "insured" or "self-insured.")

The Newborns' Act provisions always apply to coverage that is self-insured. If the plan provides benefits for hospital stays in connection with childbirth and is insured, whether the plan is subject to the Newborns' Act depends on state law. Many states have enacted their own version of the Newborns' Act for insured coverage. If your state has a law regulating coverage for newborns and mothers that meets specific criteria and coverage is provided by an insurance company or HMO, state law will apply.

All group health plans that provide maternity or newborn infant coverage must include in their Summary Plan Descriptions a statement describing the Federal or state law requirements applicable to the plan (or any health insurance coverage offered under the plan) relating to hospital length of stay in connection with childbirth for the mother or newborn child.

For more information, see the Frequently Asked Questions (FAQs) About the Newborns' and Mothers' Health Protection Act.

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 pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:

- » Cover emergency services without requiring you to get approval for services in advance (prior authorization).
- » Cover emergency services by out-of-network providers.
- » Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
- » Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the Iowa Insurance Division.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

STATE	WEBSITE/EMAIL	PHONE
Alabama Medicaid	myalhipp.com	855-692-5447
Alaska Medicaid	Premium Payment Program: myakhipp.com Medicaid Eligibility: health.alaska.gov/dpa Email: customerservice@myakhipp.com	866-251-4861
Arkansas Medicaid	http://myarhipp.com/	855-MyARHIPP (855-692-7447)
California Medicaid	dhcs.ca.gov/hipp Email: hipp@dhcs.ca.gov	916-445-8322 916-440-5676 (fax)
Colorado Medicaid and CHIP	Medicaid: healthfirstcolorado.com CHIP: hcpf.colorado.gov/child-health-plan-plus HIBI: mycohibi.com	800-221-3943 Relay 711 800-359-1991 Relay 711 855-692-6442
Florida Medicaid	flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html	877-357-3268
Georgia Medicaid	HIPP: medicaid.georgia.gov/health-insurance-premium-payment- program-hipp CHIPRA: 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	HIPP: https://www.in.gov/fssa/dfr/ All other Medicaid: in.gov/medicaid	800-403-0864 800-457-4584
Iowa Medicaid and CHIP	Medicaid: hhs.iowa.gov/programs/welcome-iowa-medicaid CHIP: hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki HIPP: hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp	800-338-8366 800-257-8563 888-346-9562
Kansas Medicaid	kancare.ks.gov	800-792-4884 HIPP: 800-967-4660
Kentucky Medicaid and CHIP	KI-HIPP: chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx KI-HIPP Email: KIHIPP.PROGRAM@ky.gov KCHIP: kynect.ky.gov Medicaid: chfs.ky.gov/agencies/dms	KI-HIPP: 855-459-6328 KCHIP: 877-524-4718
Louisiana Medicaid	ldh.la.gov/healthy-louisiana or www.ldh.la.gov/lahipp	Medicaid: 888-342-6207 LaHIPP: 855-618-5488
Maine Medicaid	Enrollment: mymaineconnection.gov/benefits Private health insurance premium: maine.gov/dhhs/ofi/applications-forms	Enroll: 800-442-6003 Private HIP: 800-977-6740 TTY/Relay: 711
Massachusetts Medicaid and CHIP	mass.gov/masshealth/pa Email: masspremassistance@accenture.com	800-862-4840 TTY/Relay: 711
Minnesota Medicaid	mn.gov/dhs/health-care-coverage	800-657-3672
Missouri Medicaid	dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
Montana Medicaid	HIPP: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP HIPP Email: HHSHIPPProgram@mt.gov	800-694-3084
Nebraska Medicaid	ACCESSNebraska.ne.gov	855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
Nevada Medicaid	Medicaid: dhcfp.nv.gov	800-992-0900
New Hampshire Medicaid	dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	603-271-5218 or 800-852-3345, ext. 15218

New Jersey Medicaid and CHIP	Medicaid: state.nj.gov/humanservices/dmahs/clients/medicaid CHIP: njfamilycare.org/index.html	Medicaid: 800-356-1561 CHIP Premium Assist: 609-631-2392 CHIP: 800-701-0710 TTY/Relay: 711
New York Medicaid	health.ny.gov/health_care/medicaid	800-541-2831
North Carolina Medicaid	medicaid.ncdhhs.gov	919-855-4100
North Dakota Medicaid	hhs.nd.gov/healthcare	844-854-4825
Oklahoma Medicaid and CHIP	insureoklahoma.org	888-365-3742
Oregon Medicaid	healthcare.oregon.gov/Pages/index.aspx	800-699-9075
Pennsylvania Medicaid and CHIP	Medicaid: pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html CHIP: dhs.pa.gov/CHIP/Pages/CHIP.aspx	Medicaid: 800-692-7462 CHIP: 800-986-KIDS (5437)
Rhode Island Medicaid and CHIP	eohhs.ri.gov	855-697-4347 or 401-462-0311 (Direct RIte)
South Carolina Medicaid	scdhhs.gov	888-549-0820
South Dakota Medicaid	dss.sd.gov	888-828-0059
Texas Medicaid	hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program	800-440-0493
Utah Medicaid and CHIP	UPP: medicaid.utah.gov/upp/ UPP Email: upp@utah.gov Adult Expansion: medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program: medicaid.utah.gov/buyout-program/ CHIP: chip.utah.gov	UPP: 877-222-2542
Vermont Medicaid	dvha.vermont.gov/members/medicaid/hipp-program	800-250-8427
Virginia Medicaid and CHIP	coverva.dmas.virginia.gov/learn/premium-assistance/famis-select coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs	Medicaid/CHIP: 800-432-5924
Washington Medicaid	hca.wa.gov	800-562-3022
West Virginia Medicaid and CHIP	dhhr.wv.gov/bms/ mywvhipp.com/	Medicaid: 304-558-1700 CHIP: 855-699-8447
Wisconsin Medicaid and CHIP	dhs.wisconsin.gov/badgercareplus/p-10095.htm	800-362-3002
Wyoming Medicaid	health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility	800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
dol.gov/agencies/ebsa
866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov
877-267-2323, Menu Option 4, ext. 61565


POLK COUNTY
Leading the Way