



# OPEN ENROLLMENT GUIDE

CALENDAR YEAR 2026



ACT is proud to offer our team members a comprehensive, competitive, and flexible suite of benefits that are market competitive. We work closely with our various plan providers to ensure team members have access to the best resources available when it comes to taking care of themselves and their families. Our guiding principles for team member benefits include providing access to market competitive core programs alongside offerings designed to create benefits that are specific to ACT and its mission.

**The open enrollment period for ACT team members will be held**

**November 3 – November 13, 2025.**

**Benefit coverage will be effective January 1 – December 31, 2026.**

## Eligibility

The benefits described in this booklet are available to all full-time and part-time ( $\geq 18.75$  hours/week) ACT team members, unless otherwise noted. Coverage is also available for dependents of eligible team members. People employed as interns and independent contractors are not eligible for the benefits described in this booklet.

### Eligible dependents include:

- Spouse
- Domestic partner, subject to affidavit
- Child under age 26

### A child includes:

- A natural child
- A legally adopted child
- A child for whom a team member has legal guardianship
- A stepchild
- A foster child

Dependent children are eligible for coverage up to age 26. Upon attaining age 26, a child may only continue coverage due to certain permanent disabilities (please contact [benefits@act.org](mailto:benefits@act.org) if you have specific questions about covering a disabled dependent age 26 or older).

**Note for spouses & domestic partners who both work at ACT:** a person may be insured only once under each benefit as an Employee, Spouse/Domestic Partner (DP), or Dependent Child. An employee who is the spouse or domestic partner of another employee may not be insured as both an Employee and as a Spouse/DP at the same time. Employees under the age of 26 who are eligible for benefits will not be eligible to be insured as both an Employee and a Dependent Child at the same time. Dependent Children may only be covered by one employed parent.

## Enrollment

Team members may elect to carry different levels of coverage for each plan – medical, dental, and/or vision insurance. For example, they may choose *Employee Only* for medical, *Employee + Spouse* for dental, and *waive (decline) vision*.

Team members may make benefit changes during the annual benefits open enrollment period, typically held each November for the following calendar year.

Elections are generally irrevocable during the year unless a qualifying life event occurs.

Team members may make changes when a qualifying life event occurs, which may permit them to add or drop benefits, change their coverage level, add or drop a dependent from their benefits, or change from one plan to another under limited circumstances.

### Examples of qualifying life events:

- Marriage
- Divorce
- Birth or adoption of a child

If you experience a qualifying life event, it is your responsibility to report that information to [benefits@act.org](mailto:benefits@act.org) **within 31 days** of the event; otherwise you will not be able to make any benefit election changes until the next annual open enrollment period. Documentation will be required to support the qualifying event. Please review the [Life Event Change Process](#) for more details.

*The information contained in this summary should in no way be construed as a guarantee of employment. ACT reserves the right to modify, amend, suspend, or terminate any plan/program at any time for any reason. If there is a conflict between the information contained here and the actual plan documents or policies, the plan documents or policies will always govern. Details, changes, and definition of terms used in this overview can be obtained by reviewing current descriptions and/or policies. It is important you understand the benefits provided to you by ACT. This document is not intended to constitute a Summary Plan Description (SPD) under ERISA. For specific details about your eligibility for benefits, coverage, and limitations under the various plans, and your responsibilities, please review the SPDs.*

## Making Choices

You have from **Monday, November 3, through Thursday, November 13, 2025**, to elect your 2026 benefits.

Annual Open Enrollment is the only time during the year you are allowed to change your benefit elections unless you experience a qualifying life event.

**OPEN ENROLLMENT** is for the following benefits:

- Medical Insurance
- Dental Insurance
- Vision Insurance
- Pre-Tax Spending Accounts (FSA & HSA)
- Legal Insurance & Identity Theft Protection
- Supplemental Life and AD&D Insurance
- Voluntary Accident Insurance
- Voluntary Critical Illness Insurance
- Voluntary Hospital Indemnity Insurance

### NAVIGATING THIS YEAR'S OPEN ENROLLMENT

#### 1. Review the information in this guide.

It is important that you understand the benefit offerings for 2026. Rates for all benefits begin on page 16 of this guide.

#### 2. Are you enrolled in the correct medical, dental, and/or vision plans?

Medical Plans A, B & C are being offered again in 2026. Be sure to read about them and decide which plan is right for you. In addition, virtual visits with Doctor On Demand will be offered at \$0 to all medical plan enrollees beginning January 1, 2026. The dental and vision plans are not changing.

#### 3. Review your dependents.

Covered dependents must meet the eligibility requirements.

#### 4. Evaluate the Health Care and/or Dependent Care Flexible Spending Account & Health Savings Account options.

- You must re-enroll in FSA every year and elect a new annual benefit amount if you wish to participate.
- If you are choosing the High Deductible Health Plan (HDHP) for 2026, you may be eligible to contribute to a Health Savings Account (HSA) and receive a company contribution. It is your responsibility to determine whether or not you are HSA-eligible.
- You may not participate in both Health FSA and HSA in 2026; you may choose either Health FSA or HSA (*if eligible*).
- You may participate in the Limited Purpose FSA (for dental and vision expenses only) and/or the Dependent Care FSA while participating in the HSA.

#### 5. Review your life and ad&d insurance amounts.

Ensure your life insurance coverage amounts meet the needs for you and your family. Take advantage of the discounted rates that team members receive for the

supplemental group term life insurance to protect you and your family.

#### 6. Review the voluntary benefits – critical illness, accident, and hospital indemnity insurance – that are being offered.

Review the included information to determine if any or all of these coverages are right for you and/or your family.

#### 7. Review and update, as necessary, all beneficiary designations for life and ad&d insurance.

#### 8. Complete the Open Enrollment process in Dayforce by Thursday, November 13, 2025.

This year, it is required that all eligible team members complete open enrollment and actively elect or waive each benefit. Current benefits will not rollover to 2026.

## Live Q&A Sessions

To help address questions you may have, the ACT Benefits Team will be hosting live Q&A sessions during open enrollment. Each session will focus primarily on either the new medical plans and FSA/HSA vendor or the new voluntary benefits, but questions about all open enrollment benefits will be accepted. Please visit the [Open Enrollment page](#) on Inform to add these sessions to your calendar. If you are not able to attend, you may email questions to [benefits@act.org](mailto:benefits@act.org).

- [Mon 11/3 @ 2pm CT](#)
- [Thurs 11/6 @ 10am CT](#)
- [Thurs 11/13 @ 3pm CT](#)

## Enrolling

Open Enrollment for benefits will be available in Dayforce beginning November 3, 2025.

You may complete the enrollment as many times as you wish while it is open. Each enrollment overwrites the previous one, so only the final information that you submit before the deadline will be counted.

To see the elections you submitted during open enrollment, log in to Dayforce, select "Benefits," then "History."

If you do not complete open enrollment by November 13, 2025, your benefits will terminate December 31, 2025.

NEVER search for Dayforce via Google, Firefox, Edge, or any other search engine. If you must access Dayforce outside ACT's network, always use the following URL.

<https://sso.dayforcehcm.com/actinc>

# Medical Insurance



ACT offers team members a choice of medical insurance options administered through Wellmark Blue Cross Blue Shield of Iowa.

## Medical Plan Options:

- **PLAN A** – Deductible = \$500 Individual / \$1,000 Family
  - Iowa HMO network available to residents of Iowa only
  - National PPO network available to residents in all states
- **PLAN B** – Deductible = \$1,500 Individual / \$3,000 Family
  - Iowa HMO network available to residents of Iowa only
  - National PPO network available to residents in all states
- **PLAN C (HDHP)** – Deductible = \$3,500 Individual / \$7,000 Family
  - National PPO network available to residents in all states
  - HSA-eligible plan

Medical rates are listed on pages 16-18.

For details on each plan, visit the next page or review the side-by-side [Medical Plans Comparison](#) document. For a list of network providers, visit the [Wellmark provider search](#).

Plan A HMO	Plan A PPO	Plan B HMO	Plan B PPO	Plan C PPO
<i>Iowa only</i>	<i>all states</i>	<i>Iowa only</i>	<i>all states</i>	<i>all states</i>
Summary Plan Description (SPD)*	Summary Plan Description (SPD)*	Summary Plan Description (SPD)*	Summary Plan Description (SPD)*	Summary Plan Description (SPD)*
Summary of Benefits & Coverage (SBC)**	Summary of Benefits & Coverage (SBC)**	Summary of Benefits & Coverage (SBC)**	Summary of Benefits & Coverage (SBC)**	Summary of Benefits & Coverage (SBC)**

\*Summary Plan Descriptions (SPDs) are typically updated and made available after the beginning of the plan year; these links contain the most current versions of SPDs we have received from Wellmark.

\*\*SBCs are not yet available for 2026. We will add links as soon as we receive updated SBCs.

## Prescription Drug Coverage

The ACT medical plans include payment for prescription drugs under the Wellmark’s Blue Rx Value Plus formulary – including in-network retail pharmacies, mail order, and a specialty drug program. Please click the links below to learn more about these pharmacy programs.

Mail Order Prescription Service: [Getting Started with Mail Order Service](#)

Specialty Drug: [Enrolling with CVS Specialty™](#)

# 2026 OPEN ENROLLMENT GUIDE

## Medical Plan Details

Below is a high-level comparison of the 2026 medical plan options and the in-network costs. For more details, including coverage for non-network services, please review the [Medical Plans Comparison](#) document.

	Plan A \$500 Deductible		Plan B \$1,500 Deductible		Plan C \$3,500 HDHP	
<b>NETWORKS AVAILABLE</b>	HMO (Iowa only) PPO (all states)		HMO (Iowa only) PPO (all states)		PPO (all states)	
<b>OFFICE VISIT COPAYMENTS</b>						
Primary Care	\$25		\$25		Subject to deductible	
Specialist	\$50		\$50		Subject to deductible	
Urgent Care	\$25		\$25		Subject to deductible	
Mental Health	\$0		\$0		Subject to deductible	
<b>DR. ON DEMAND COPAYMENTS</b>						
Medical	\$0		\$0		\$0	
Mental Health	\$0		\$0		\$0	
<b>DEDUCTIBLE</b>	\$500 Individual   \$1,000 Family		\$1,500 Individual   \$3,000 Family		\$3,500 Individual   \$7,000 Family	
<b>COINSURANCE</b>	Plan Pays 80%	You Pay 20%	Plan Pays 80%	You Pay 20%	Plan Pays 100% after deductible	You Pay Deductible, 0% coins
<b>OUT-OF-POCKET MAXIMUM</b>	\$2,000 Individual   \$4,000 Family		\$5,000 Individual   \$10,000 Family		\$3,500 Individual   \$7,000 Family	
<b>PRESCRIPTION DRUGS</b> <i>Non-specialty, In-Network only</i>						
Tier 1	\$10 Retail; \$30 Mail Order		\$10 Retail; \$30 Mail Order		Deductible, 0% coinsurance	
Tier 2	See full <a href="#">plan comparison</a>		See full <a href="#">plan comparison</a>			
Tier 3	See full <a href="#">plan comparison</a>		See full <a href="#">plan comparison</a>			
<b>EMERGENCY ROOM VISITS</b>	\$150 copay + 20% coinsurance (after deductible)		\$150 copay + 20% coinsurance (after deductible)		Deductible, 0% coinsurance	
<b>HOSPITAL SERVICES</b>	Plan Pays 80% after deductible	You Pay Deductible, 20% coins	Plan Pays 80% after deductible	You Pay Deductible, 20% coins	Plan Pays 100% after deductible	You Pay Deductible, 0% coins
<b>PREVENTIVE EXAMS</b>	Plan Pays 100%	You Pay 0%	Plan Pays 100%	You Pay 0%	Plan Pays 100%	You Pay 0%

### How does the High Deductible Health Plan (HDHP) work?

A High Deductible Health Plan (HDHP) is a medical insurance plan that has lower premiums and a higher deductible than traditional plans. When members visit their physician or fill a prescription, the insurance carrier will first reduce the total cost by any network savings that are available, then the covered member pays 100% of the remaining costs. Once the member (or family) has paid their full deductible for the year, all future covered services that year – including prescriptions – are paid 100% by the plan.

### Why consider the HDHP?

In addition to lower biweekly premiums, being covered by a High Deductible Health Plan (HDHP) makes you eligible to contribute to a Health Savings Account (HSA), which has many tax advantages. Read more about HSAs starting on page 8.

### I live in Iowa and am interested in Plan A or Plan B. Should I choose the HMO or PPO?

While the HMO (available with Plans A & B only) does have a narrower network and is limited to providers in the state of Iowa, many in-network physicians are the same in the HMO and PPO. The premiums for the HMO are lower, as well as the allowable cost of many services. To find out if your provider is in the HMO network, visit the [Wellmark provider search](#).

### Why consider the Iowa HMO network?

The negotiated contracts between Wellmark BCBS and the providers in the Wellmark Blue HMO network typically result in lower allowable charges (the amount the doctor is allowed to charge) than the same services under the Wellmark Blue PPO. Since you pay 20% of allowable charges after your deductible is satisfied, your portion will be less if the allowable charges are lower. This savings is in addition to the lower biweekly premiums for the HMO (Plans A & B). Read this [HMO vs. PPO](#) document to learn more.

### More features included with all three medical plan options:

#### Preventive Exams

Most preventative services are paid 100% by the ACT medical plans, even if you haven't yet reached your annual deductible. Review [Wellmark's Preventive Services List](#) to learn what's covered.

#### Virtual Health Visits

Virtual visits with your in-network provider will be paid at the same rate as if you went to their office for an in-person visit.

#### Doctor On Demand

ACT health plan members have access to **\$0 (NEW! Effective January 1, 2026, costs will be waived!)** virtual health visits through Doctor On Demand. Download the mobile app to your smartphone or tablet today, and follow the instructions in the [Doctor On Demand User Guide](#).

#### BeWell 24/7

Wellmark BCBS offers its members a toll-free nurse line. Speak to a trained health professional about your symptoms anytime – day or night – by calling 1-844-842-3935.

#### Medical Coverage Abroad

As a Blue Cross and Blue Shield Plan member, your health care benefits are with you at home and abroad. Outside the United States, you have access to doctors and hospitals in more than 200 countries and territories around the world through the Blue Cross Blue Shield Global (BCBS Global) Core Program. [Access this flyer](#) to learn more.

#### Blue365 Discounts

[Blue365](#) offers health plan members nationwide discounts on a variety of health, wellness, and lifestyle products & services. Learn more by reading [this flyer](#) (note: you will need your Wellmark BCBS member # to register).

# Flexible Spending & Health Savings Accounts

## Flexible Spending Accounts (FSA)

A Flexible Spending Account (FSA) lets you set aside money, on a pre-tax basis, for certain health care and dependent care expenses. There are two types of FSA accounts:

- 1) Health Care FSA (HCFSA) | 2026 annual maximum = \$3,400
- 2) Dependent Care FSA (DCFSA) | 2026 annual maximum = \$7,500 per household
- 3) **New!** Limited Purpose FSA (LPFSA) | 2026 annual maximum = \$3,400

FSA funds are “use it or lose it” (with the exception of a partial carryover opportunity with the Health Care FSA). Remember to estimate your expenses as accurately as possible, as unused funds may be forfeited. All reimbursements for eligible expenses must be requested from WEX by March 30 after the plan year ends.



### Health Care FSA (HCFSA)

During the year, participants have access to their [HCFSA](#) funds for reimbursement of expenses, such as:

- Deductibles, co-pays, and other eligible expenses not covered by insurance
- Prescription drug costs
- Certain over-the-counter medication and supplies
- Dental services, orthodontics, and dentures
- Eyeglasses, contacts, solutions, and eye surgery

When you use pre-tax dollars to pay for these expenses, you realize an increase in your spending power and substantial tax savings. Use this online [FSA Calculator](#) to estimate your potential tax savings.

### Dependent Care FSA (DCFSA)

Participants can also set up a [DCFSA](#) to be reimbursed for eligible child care expenses that are incurred while the team member works. Expenses such as:

- Dependent care expenses incurred for services outside the home for children under age 13 (or potentially a dependent adult if they meet certain eligibility requirements) – provider must be over 18 and not a tax dependent of the participant
- Registration fees to a daycare facility (fees must be allocated to actual care and not materials or other fees)
- Nursery school and preschool
- Before and after school care program
- Nanny expenses related to in-home dependent care

Use this online [Dependent Care FSA Savings Calculator](#) to estimate your potential tax savings.

### Limited Purpose FSA (LPFSA) **NEW!**

The [Limited Purpose FSA](#) is designed specifically for those who are enrolled in a High Deductible Health Plan (HDHP) with an HSA. Unlike the Health Care FSA, the LPFSA is compatible with an HSA, allowing you to contribute to both accounts simultaneously.

The **LPFSA** can be used to pay for eligible **dental and vision expenses only**, such as:

- Dental cleanings, fillings, crowns, and orthodontia
- Vision exams, prescription glasses, and contact lenses

Limited Purpose FSA funds cannot be used for general medical expenses like doctor visits or prescriptions. By using the LPFSA for dental and vision costs, you can preserve your HSA funds for broader medical needs or long-term savings. Use this online [Limited Purpose FSA Calculator](#) to estimate your potential tax savings.

**Health Savings Accounts (HSA)**

A [Health Savings Account \(HSA\)](#) is a tax-advantaged savings account available to taxpayers in the United States who are enrolled in a High Deductible Health Plan (HDHP). Unlike a Flexible Spending Account (FSA), funds roll over and accumulate year to year if not spent. HSAs are owned by the individual and may be used to pay for qualified [health care expenses](#) at any time without federal tax liability or penalty.

**Advantages of choosing the Health Savings Account**

- You don't pay taxes on money going into your HSA.
- You may change your contribution amount any time during the year.
- Any unused money at the end of the year stays in your account.
- You own the account, so the money is yours even if you change jobs.
- Once you've saved at least \$2,000 in your HSA, WEX will allow you to begin investing your funds. View the investment options [here](#).
- In 2026, ACT will contribute \$600 to your HSA if you elect the HDHP medical insurance for yourself (no dependents) or \$1,200 to your HSA if you elect HDHP medical insurance for yourself and covered dependent(s) for the full plan year. This amount will be divided by 26 and deposited each pay period. *Please Note: ACT's contribution to the HSA does count toward the IRS annual contribution limit.*

Learn more about Health Savings Accounts by reading the [HSA Overview](#) flyer.

IMPORTANT: it is your responsibility to confirm you are HSA-eligible before enrolling.

	<b>HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA)</b>	<b>HEALTH SAVINGS ACCOUNT (HSA)</b>
<b>CONTRIBUTION LIMITS FOR 2026, AS DETERMINED BY THE IRS</b>	\$3,400	\$4,400 Individual ( <i>incl. \$600 from ACT</i> ) \$8,750 Family ( <i>incl. \$1,200 from ACT</i> ) \$1,000 Catch Up ( <i>age 55+</i> )
<b>TAX-FREE CONTRIBUTION?</b>	Yes	Yes
<b>ARE MY CONTRIBUTIONS PAYROLL DEDUCTED?</b>	Yes	Yes, with the option to make additional contributions directly to WEX
<b>CAN I CHANGE MY CONTRIBUTION AMOUNT?</b>	No ( <i>unless a qualifying event occurs</i> )	Yes
<b>WILL ACT CONTRIBUTE MONEY TO MY ACCOUNT?</b>	No	\$600* Individual \$1,200* Family <i>*counts toward your annual max contribution</i>
<b>WHAT IF I DON'T USE ALL OF MY MONEY BY DECEMBER 31?</b>	You can carry over up to \$680* to 2027 <i>*amount determined by IRS each year</i>	Unused funds remain in your account
<b>WHAT IF I LEAVE ACT?</b>	You have up to 90 days to submit reimbursement requests for expenses incurred through your last day of employment	The account and all funds in it are yours to keep
<b>WHAT EXPENSES CAN I USE THE MONEY FOR?</b>	Medical, Dental, Vision, RX	Medical, Dental, Vision, RX
<b>HOW MUCH MONEY CAN I USE AT ONE TIME?</b>	As of January 1st, you have the full value of your annual election available to use.	You can use only the funds that have been deposited into your HSA so far
<b>WILL I GET A DEBIT CARD?</b>	Yes	Yes

### Do I qualify for a Health Savings Account (HSA)?

To qualify, you must be enrolled in a High Deductible Health Plan (HDHP). The HDHP must be your only health insurance (you may not be enrolled in your spouse's non-HDHP plan or in Medicare for secondary insurance). If you have a spouse who uses your insurance as a secondary coverage, he or she must also be enrolled in a High Deductible Health Plan (either through ACT or their own employer). You must not be covered by a Health Care FSA account (either your own or your spouse's) in order to contribute to an HSA. It is **your responsibility** to know whether or not you are eligible to contribute to an HSA, and to waive the HSA option if you are not eligible.

### Can I have both a Health Care Flexible Spending Account (FSA) and a Health Savings Account (HSA)?

No. To pay for qualified health expenses, you may choose either an FSA or an HSA. You may not have both.

However, HSA enrollment will not interfere with your ability to enroll in a Dependent Care FSA.

### If I choose the HDHP medical plan, am I required to participate in the HSA?

No. While it is a requirement of the HSA to be enrolled in the HDHP, the reverse is not true. Team members who choose the HDHP medical plan are not required to enroll in the HSA. Enrollment is optional.

Learn more about how an HSA & HDHP work by reading [this Inform post](#).

## Tools from WEX for FSA & HSA participants:

### Eligible Expenses

There are hundreds of eligible health expenses on which HCFSAs & HSA funds can be spent. Explore WEX's interactive [Eligible Expenses](#) list to learn more.

### WEX Benefits Mobile App

With the WEX mobile app, you can check your balance, file a claim for reimbursement, upload documents, and more. View the [WEX Mobile App](#) flyer for more information.

### Online Account Access

WEX offers participants online account access at [www.wexinc.com](http://www.wexinc.com).

### Debit Card

WEX provides debit cards to participants to make spending easy.

- Use your debit card to at the pharmacy or to pay your physician
- Swipe your card at the register to pay for eligible expenses at stores like CVS, Walgreens, Walmart, or Target
- Load your card into Apple Pay, Samsung Pay, or Google Pay
- Shop online for eligible items at FSASTore.com or HSASTore.com

Learn more by reviewing the [WEX Debit Card](#) flyer.

## What if I have funds remaining in my 2025 Health FSA and want to switch to HSA in 2026?

Since you are not allowed to contribute to an HSA while you have access to Health Care FSA funds, you will want your rollover amount to be converted into a Limited Purpose FSA (LPFSA) at WEX for use in 2027. This will not interfere with your eligibility to contribute to the HSA.

# Dental Insurance



ACT offers team members two dental plan options, administered through Delta Dental of Iowa.

## Dental Plan Options:

**Dental rates are listed on page 18.**

1. Basic Plan
2. Enhanced Plan – *includes greater annual benefit and orthodontia coverage for children under age 19*

Plan provisions within the two options are similar. Specifics can be found by reviewing the side-by-side comparison found in the [Summary of Covered Services](#). For full plan information, please refer to the Summary Plan Description (SPD) for the [Basic Plan](#) or [Enhanced Plan](#). For a list of network providers, visit the [Delta Dental provider search](#).

	BASIC PLAN	ENHANCED PLAN
<b>DEDUCTIBLE</b> <i>(Waived for preventive services)</i>	Individual \$25   Family \$75	Individual \$25   Family \$75
<b>PREVENTIVE SERVICES</b>	Plan pays 100%   You pay 0%	Plan pays 100%   You pay 0%
<b>ROUTINE &amp; RESTORATIVE</b> <i>(Cavity repair and tooth extractions)</i>	Plan pays 80%   You pay 20%	Plan pays 80%   You pay 20%
<b>MAJOR SERVICES</b> <i>(Limits vary by service)</i>	Plan pays 50%   You pay 50%	Plan pays 50%   You pay 50%
<b>ORTHODONTIA</b> <i>(Children under age 19 only)</i>	Not covered	Plan pays 50%   You pay 50%
<b>MAXIMUM BENEFITS</b>	<b>PREVENTIVE, ROUTINE, &amp; RESTORATIVE, and MAJOR:</b> \$1,000 benefit per calendar year, per person <i>(up to \$2,000 with To-Go Carryover*)</i>	<b>PREVENTIVE, ROUTINE, &amp; RESTORATIVE, and MAJOR:</b> \$2,500 benefit per calendar year, per person <i>(up to \$5,000 with To-Go Carryover*)</i>  <b>ORTHODONTIA:</b> \$2,500 lifetime maximum per dependent <i>(only children under age 19 are eligible, and they must remain on the Enhanced Plan for the entire duration of orthodontic treatment)</i>
<b>ENHANCED BENEFIT PROGRAM</b>	Included	Included
<b>TO GO – ANNUAL CARRYOVER</b>	Included	Included

### “To Go” Carryover Feature

Members who are covered the full calendar year may be eligible to carry over their unused benefits to the following year. Read the [To Go Flyer](#) for complete details.

# Vision Insurance



ACT offers team members and their families high-quality vision coverage for in-network and out-of-network vision providers. Vision insurance is provided through Avēsis. For a list of network providers, visit the [Avēsis provider search](#).

For more specifics on plan benefits, refer to the schedule of benefits: [Avēsis Vision Overview](#) (there are no changes for 2026).

	IN NETWORK	NON-NETWORK	FREQUENCY
<b>EXAMS</b>	<b>ROUTINE:</b> \$10 copay	<b>ROUTINE:</b> Reimbursed up to \$35	Once every 12 months
<b>CONTACTS</b> <i>(in lieu of frames &amp; lenses)</i>	<b>ELECTIVE:</b> \$150 allowance <b>MEDICALLY NECESSARY:</b> \$10 copay	<b>ELECTIVE:</b> Reimbursed up to \$130 <b>MEDICALLY NECESSARY:</b> Reimbursed up to \$250	Once every 12 months
<b>VISION LENSES</b> <i>(in lieu of contacts)</i>	<b>SINGLE:</b> \$10 copay <b>BIFOCAL:</b> \$10 copay <b>TRIFOCAL:</b> \$10 copay <b>LENTICULAR:</b> \$10 copay <b>PROGRESSIVE (LEVEL 1):</b> \$0 copay <b>PROGRESSIVE (LEVEL 2):</b> \$0 copay <b>ALL OTHER PROGRESSIVE:</b> \$140 allowance	<b>SINGLE:</b> Reimbursed up to \$25 <b>BIFOCAL:</b> Reimbursed up to \$25 <b>TRIFOCAL:</b> Reimbursed up to \$25 <b>LENTICULAR:</b> Reimbursed up to \$25 <b>PROGRESSIVE (LEVEL 1):</b> Reimbursed up to \$40 <b>PROGRESSIVE (LEVEL 2):</b> Reimbursed up to \$48 <b>ALL OTHER PROGRESSIVE:</b> Reimbursed up to \$48	Once every 12 months
<b>FRAMES</b>	\$50 wholesale allowance (up to \$150 retail value)	Reimbursed up to \$45	Once every 12 months
<b>REFRACTIVE LASER SURGERY</b>	\$150 allowance + provider discount	\$150 allowance	Once per lifetime

Team members are responsible for costs that exceed the covered allowances. Check with your provider to determine any charges that may apply, as options with the allowances may be limited based on your provider.

Interested in LASIK? Read about the [QualSight LASIK program](#) for Avēsis members.

**Vision & Legal rates are listed on page 19.**

# Legal Insurance & Identify Theft Protection



Legal insurance provides access to ARAG's network of over 14,000 attorneys, covers a wide range of legal matters, gives you access to a toll-free assistance line, and can help you create important legal documents. This coverage also provides identity theft protection and restoration services.

ARAG's UltimateAdvisor® Plan covers you, your spouse/domestic partner, and your children up to age 26. Read more details in the [Legal Insurance Overview](#) flyer.

# Supplemental Life Insurance



Team members have the opportunity to purchase Supplemental Term Life insurance and Accidental Death & Dismemberment (AD&D) insurance for themselves, their spouse/domestic partner, and their eligible dependent children. Supplemental Term Life pays a benefit to the team member's chosen beneficiary in the event of a team member's death, or to the team member in the event of the covered dependent's death. AD&D insurance pays a benefit if the death is a result of an accident. Read the highlights [here](#).

Evidence of Insurability (EOI) will be required for any new elections or increases during open enrollment. If you request to add or increase supplemental life insurance for yourself and/or your spouse/domestic partner, you will be sent a link to an online EOI health questionnaire after open enrollment ends.

- If you do not currently have supplemental life insurance for yourself or spouse/DP, EOI will be required for any purchase this year.
- If you currently have supplemental life insurance for yourself and/or spouse/DP and you request to increase the amount, EOI will be required.
- EOI does not apply to supplemental child life or to any AD&D coverage, so these amounts may be purchased up to the associated maximum without answering health questions.
- To be eligible to purchase supplemental insurance for your dependents, you must purchase supplemental coverage for yourself.
- If you wish to reduce or cancel your supplemental life insurance during open enrollment, you may do so without any restrictions.

The table below describes the supplemental coverage available.

	Purchase Amounts	Maximum Coverage
<b>Supp Life Insurance - SELF</b>	Increments of \$10,000	\$500,000 <i>(not to exceed 5x employee base salary)</i>
<b>Supp Life Insurance – SPOUSE*</b> <i>(includes domestic partners)</i>	Increments of \$5,000	\$250,000 <i>(not to exceed employee's approved amount)</i>
<b>Supp Life Insurance – CHILD(REN)*</b>	\$5,000 or \$10,000	\$10,000
<b>Supp AD&amp;D – SELF</b>	Increments of \$10,000	\$500,000 <i>(not to exceed 5x employee base salary)</i>
<b>Supp AD&amp;D – SPOUSE*</b> <i>(includes domestic partners)</i>	Increments of \$5,000	\$250,000 <i>(not to exceed employee's approved amount)</i>
<b>Supp AD&amp;D – CHILD(REN)*</b>	\$5,000 or \$10,000	\$10,000

**\* IMPORTANT note for spouses & domestic partners who both work at ACT:** A person may be insured only once under the Policy as an Employee, Spouse/DP, or Dependent Child. An employee who is the spouse or domestic partner of another employee may not be insured as both an Employee and as a Spouse/DP at the same time. Employees under the age of 26 who are eligible for Supplemental Life Insurance or AD&D will not be eligible to be insured as a Dependent Child of another employee. Dependent Children may only be covered by one employed parent.

# Voluntary Benefits

Reliance Matrix offers three voluntary benefit plans to ACT's benefits-eligible team members, their spouses or domestic partners, and their children (under age 26). Learn more by visiting the [Voluntary Benefits Inform page](#).

## Voluntary Benefit Plans:

- **Hospital Indemnity Insurance**
- **Accident Insurance**
- **Critical Illness Insurance**

Supplemental Life, AD&D, and Voluntary Benefits rates are listed on pages 19-21.

## Voluntary Benefit Plans are easy to choose and easy to use.

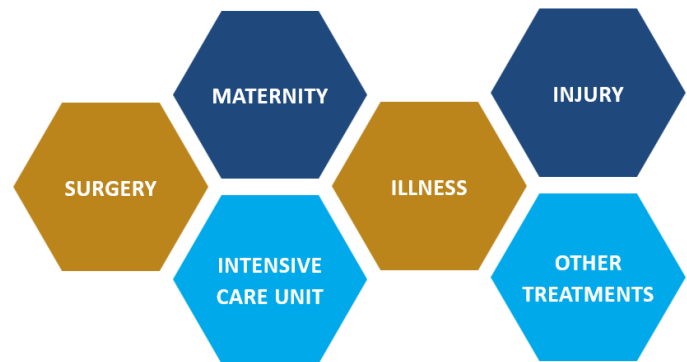
- Guaranteed issue with no medical questions
- No pre-existing condition limitations
- No waiting period
- Benefits paid directly to you
- Payments are not offset by any other coverage (including medical insurance)
- Portable at current costs

## Voluntary Hospital Indemnity Insurance (VHI)

Hospital indemnity insurance supplements your existing health insurance by providing cash benefits to help pay for out-of-pocket expenses due to hospital stays, whether planned or unplanned. Benefits are paid directly to the insured following a hospitalization that meets the criteria. Examples include, but are not limited to giving birth, surgery, injury, and prolonged illness.

Click here to watch a quick VHI video.

FEATURE	BENEFIT AMOUNT
Hospital Admission Benefit <i>1 per year</i>	\$1,500
Hospital Confinement <i>90 days per year</i>	\$200
ICU Confinement <i>30 days per year</i>	\$400
Nursery Admission Benefit <i>1 per year</i>	\$1,000
Nursery Confinement Benefit <i>10 days per year</i>	\$100



### Voluntary Accident Insurance (VAI)

Accidents and injuries can happen anywhere – at home or on the road, at school or work, during sporting activities, and more. Accident insurance can provide protection against unexpected out-of-pocket medical expenses due to an accidental injury, such as co-pays, deductibles, and coinsurance amounts. The lump sum benefits are paid directly to you and may be used for any reason, including doctor bills, income supplement, childcare, etc. There is no limit on the number of times the policy can be used.

Click here to watch a quick VAI video.

**Partial Schedule of Benefits:**

SERVICE	BENEFIT AMOUNT
Ambulance	\$300 Ground \$1,500 Air
Burns	Up to \$1,600 for 2nd degree burns Up to \$12,800 for 3rd degree burns Skin Graft - 50.00% of benefit payable for Burns
Concussion	\$250
Dental Injury	\$351 for Crown \$117 for Extraction
Hospital Confinement	\$200 per day
Lacerations	Up to \$600
Physician Visit	\$95 (up to 6)
X-Rays	\$75

**Find the full schedule of benefit payments in the [Voluntary Accident Insurance Highlights flyer](#)**

### VAI Wellness Benefit

In addition to payments for accidental injuries, VAI contains a Wellness Benefit that pays each covered member (up to 4 per family) **\$50** annually for submitting evidence of completing a qualified preventive health screening. Health screenings include, but are not limited to routine exams (including dental, vision, and hearing), immunizations, and tests (glucose, cholesterol, PAP, PSA, stress test, and more). For a full list, please review the [Voluntary Benefits Wellness Screening Credit flyer](#).

**Voluntary Critical Illness Insurance (VCI)**

Critical illness insurance pays a fixed, lump-sum benefit upon diagnosis of a covered critical illness, which may include heart attack, stroke, cancer, organ failure, paralysis, and more. The benefits are paid directly to the insured and may be used for any reason, including out-of-pocket treatment costs, income supplement, transportation, etc.

Click here to watch a quick VCI video.

ADULT AND CHILD COVERED CONDITIONS			ADDITIONAL CHILDHOOD COVERED CONDITIONS
Acute Respiratory Distress Syndrome (25%)	Invasive Cancer	Occupational HIV	Cerebral Palsy
Alzheimer’s Disease	Loss of Hearing	Paralysis	Cleft Lip or Palate
Carcinoma in situ (25%)	Loss of Sight	Parkinson’s Disease (50%)	Cystic Fibrosis
Coma	Loss of Speech	Ruptured Cerebral, Carotid, or Aortic Aneurysm (25%)	Down Syndrome
Coronary Disease (50%)	Major Organ Failure	Severe Brain Damage	Muscular Dystrophy
Heart Attack	Motor Neuron Disease	Skin Cancer (10%)	Spina Bifida
	Multiple Sclerosis (50%)	Stroke	Type I Diabetes

	Purchase Amounts	Maximum Coverage	Guaranteed Issue (GI)
<b>VCI Insurance – SELF</b>	Increments of \$5,000	\$30,000	\$30,000
<b>VCI Insurance – SPOUSE*</b> <i>(includes domestic partners)</i>	Increments of \$5,000	\$30,000 <i>(not to exceed 100% of employee amount)</i>	\$30,000
<b>VCI Insurance – CHILD(REN)*</b> <i>(this coverage is automatically added at no cost for all eligible dependent children when you choose coverage for yourself)</i>	50% of employee amount	\$15,000	\$15,000

**VCI Wellness Benefit**

In addition to payments for critical illness diagnoses, VCI contains a Wellness Benefit that pays each covered member (up to 4 per family) **\$100** annually for submitting evidence of completing a qualified preventive health screening. Health screenings include, but are not limited to routine exams (including dental, vision, and hearing), immunizations, and tests (glucose, cholesterol, PAP, PSA, stress test, and more). For a full list, please review the [Voluntary Benefits Wellness Screening Credit](#) flyer.

## 2026 Rates

The tables below display the costs associated for various benefit plan options in 2025. The blue amounts are paid by the team member through biweekly payroll deductions.

### Pre-Tax Deductions (biweekly):

<b>MEDICAL – PLAN A</b> \$500 Deductible			
<b>Wellmark Blue HMO</b> <i>only available in Iowa</i>	<b>Team Member Cost Per Pay Period</b>	ACT Cost Per Pay Period	Total Cost Per Pay Period
TM Only	<b>\$70.81</b>	\$265.10	\$335.91
TM + Spouse	<b>\$137.90</b>	\$550.04	\$687.94
TM + Child(ren)	<b>\$127.73</b>	\$508.14	\$635.87
TM + Family	<b>\$208.80</b>	\$822.08	\$1,030.89
<b>Wellmark Blue PPO</b> <i>Costs for Team Members who live in Iowa</i>	<b>Team Member Cost Per Pay Period</b>	ACT Cost Per Pay Period	Total Cost Per Pay Period
TM Only	<b>\$92.91</b>	\$279.61	\$372.52
TM + Spouse	<b>\$181.21</b>	\$581.72	\$762.93
TM + Child(ren)	<b>\$171.06</b>	\$534.12	\$705.18
TM + Family	<b>\$270.56</b>	\$872.70	\$1,143.27
<b>Wellmark Blue PPO</b> <i>Costs for Team Members who live outside of Iowa</i>	<b>Team Member Cost Per Pay Period</b>	ACT Cost Per Pay Period	Total Cost Per Pay Period
TM Only	<b>\$76.28</b>	\$296.24	\$372.52
TM + Spouse	<b>\$152.71</b>	\$610.21	\$762.93
TM + Child(ren)	<b>\$143.29</b>	\$561.89	\$705.18
TM + Family	<b>\$230.07</b>	\$913.20	\$1,143.27

Please note: the IRS requires the value of coverage specific to a **Domestic Partner and/or Domestic Partner's children** be **post-tax** (pre-tax is only applicable to the team member and their legal spouse & children). To view the pre- and post-tax splits for medical, dental, and vision rates for Domestic Partners, click [here](#).

<b>MEDICAL – PLAN B</b> <i>\$1,500 Deductible</i>			
<b>Wellmark Blue HMO</b> <i>only available in Iowa</i>	<b>Team Member Cost Per Pay Period</b>	ACT Cost Per Pay Period	Total Cost Per Pay Period
TM Only	<b>\$56.92</b>	\$257.26	\$314.18
TM + Spouse	<b>\$115.30</b>	\$528.15	\$643.45
TM + Child(ren)	<b>\$106.95</b>	\$487.80	\$594.75
TM + Family	<b>\$172.78</b>	\$791.45	\$964.23
<b>Wellmark Blue PPO</b> <i>Costs for Team Members who live in Iowa</i>	<b>Team Member Cost Per Pay Period</b>	ACT Cost Per Pay Period	Total Cost Per Pay Period
TM Only	<b>\$74.80</b>	\$273.03	\$347.83
TM + Spouse	<b>\$152.22</b>	\$560.13	\$712.35
TM + Child(ren)	<b>\$142.62</b>	\$515.82	\$658.44
TM + Family	<b>\$229.14</b>	\$838.34	\$1,067.49
<b>Wellmark Blue PPO</b> <i>Costs for Team Members who live outside of Iowa</i>	<b>Team Member Cost Per Pay Period</b>	ACT Cost Per Pay Period	Total Cost Per Pay Period
TM Only	<b>\$60.75</b>	\$287.08	\$347.83
TM + Spouse	<b>\$123.65</b>	\$588.70	\$712.35
TM + Child(ren)	<b>\$114.70</b>	\$543.74	\$658.44
TM + Family	<b>\$186.29</b>	\$881.20	\$1,067.49

Please note: the IRS requires that the value of coverage specific to a **Domestic Partner and/or Domestic Partner's children** be **post-tax** (pre-tax is only applicable to the team member and their legal spouse & children). To view the pre- and post-tax splits for medical, dental, and vision rates for Domestic Partners, click [here](#).

MEDICAL – PLAN C \$3,500 HDHP			
Wellmark Blue PPO <i>All States</i>	Team Member Cost Per Pay Period	ACT Cost Per Pay Period	Total Cost Per Pay Period
TM Only	\$53.06	\$270.54	\$323.61
TM + Spouse	\$106.97	\$555.78	\$662.75
TM + Child(ren)	\$99.73	\$512.85	\$612.59
TM + Family	\$160.66	\$832.49	\$993.15

DENTAL INSURANCE			
BASIC PLAN	Team Member Cost Per Pay Period	ACT Cost Per Pay Period	Total Cost Per Pay Period
TM Only	\$3.37	\$13.49	\$16.86
TM + Spouse	\$6.73	\$26.93	\$33.66
TM + Child(ren)	\$6.73	\$26.93	\$33.66
TM + Family	\$9.02	\$36.10	\$45.12
ENHANCED PLAN	Team Member Cost Per Pay Period	ACT Cost Per Pay Period	Total Cost Per Pay Period
TM Only	\$5.33	\$15.98	\$21.30
TM + Spouse	\$10.65	\$31.96	\$42.61
TM + Child(ren)	\$12.66	\$37.98	\$50.64
TM + Family	\$16.45	\$49.36	\$65.81

Please note: the IRS requires that the value of coverage specific to a **Domestic Partner and/or Domestic Partner's children** be **post-tax** (pre-tax is only applicable to the team member and their legal spouse & children). To view the pre- and post-tax splits for medical, dental, and vision rates for Domestic Partners, click [here](#).

VISION INSURANCE			
	Team Member Cost Per Pay Period	ACT Cost Per Pay Period	Total Cost Per Pay Period
TM Only	\$4.68	\$0.00	\$4.68
TM + Spouse	\$8.94	\$0.00	\$8.94
TM + Child(ren)	\$9.75	\$0.00	\$9.75
TM + Family	\$12.56	\$0.00	\$12.56

Please note: the IRS requires that the value of coverage specific to a **Domestic Partner and/or Domestic Partner's children** be **post-tax** (pre-tax is only applicable to the team member and their legal spouse & children). To view the pre- and post-tax splits for medical, dental, and vision rates for Domestic Partners, click [here](#).

**Post-Tax Deductions (biweekly):**

LEGAL INSURANCE	
	Cost Per Pay Period
UltimateAdvisor® Plan	\$11.25

SUPPLEMENTAL LIFE INSURANCE		
	EMPLOYEE COVERAGE	SPOUSE COVERAGE
Age	Cost Per Pay Period Per <u>\$10,000</u>	Cost Per Pay Period Per <u>\$5,000</u>
< 25	\$0.231	\$0.115
25 – 39	\$0.277	\$0.138
40 – 49	\$0.415	\$0.208
50 – 54	\$0.738	\$0.369
55 – 59	\$1.246	\$0.623
60 – 64	\$1.892	\$0.946
65 – 69	\$2.769	\$1.385
70 +	\$8.077	\$4.038

**SUPPLEMENTAL LIFE INSURANCE – CHILD(REN)**

Increment	Cost Per Pay Period
\$5,000	\$0.462
\$10,000	\$0.924

**SUPPLEMENTAL AD&D INSURANCE**

EMPLOYEE COVERAGE	SPOUSE COVERAGE	CHILD COVERAGE
Cost Per Pay Period Per <u>\$10,000</u>	Cost Per Pay Period Per <u>\$5,000</u>	Cost Per Pay Period Per <u>\$5,000</u>
\$0.115	\$0.058	\$0.058

**VOLUNTARY ACCIDENT INSURANCE**

Tier	Cost Per Pay Period
TM Only	\$4.62
TM + Spouse	\$7.57
TM + Child(ren)	\$10.43
TM + Family	\$13.43

**VOLUNTARY HOSPITAL INDEMNITY INSURANCE**

Tier	Cost Per Pay Period
TM Only	\$12.83
TM + Spouse	\$23.49
TM + Child(ren)	\$18.83
TM + Family	\$29.17

VOLUNTARY CRITICAL ILLNESS INSURANCE		
	EMPLOYEE COVERAGE	SPOUSE COVERAGE
Age	Cost Per Pay Period Per <u>\$5,000</u>	Cost Per Pay Period Per <u>\$5,000</u>
< 30	\$0.88	\$0.88
30 – 39	\$1.62	\$1.62
40 – 49	\$2.54	\$2.54
50 – 59	\$5.31	\$5.31
60 – 69	\$10.38	\$10.38
70 +	\$23.08	\$23.08

## Contact Information

BENEFIT	CARRIER	CUSTOMER SERVICE	WEBSITE
MEDICAL INSURANCE	Wellmark Blue Cross Blue Shield of Iowa Group #73813	Customer Service: 866-515-1456  Precertification: 800-558-4409	<a href="http://www.wellmark.com">www.wellmark.com</a>
DENTAL INSURANCE	Delta Dental of Iowa Group #32331	Customer Service: 800-544-0718	<a href="http://www.deltadentalia.com">www.deltadentalia.com</a>
VISION INSURANCE	Avēsis Group #60790	Customer Service: 855-214-6777	<a href="http://www.avesis.com">www.avesis.com</a>
SPENDING ACCOUNTS (FSA & HSA)	WEX	Customer Service: 866-451-3399	<a href="http://www.wexinc.com">www.wexinc.com</a>
LIFE INS, AD&D INS, VOLUNTARY BENEFITS (ACCIDENT, CRITICAL ILLNESS & HOSPITAL INDEMNITY), STD, LTD, and LEAVE OF ABSENCE	Reliance Matrix <i>Reliance Standard Life Insurance Company</i> <i>Matrix Absence Management</i>	Customer Service: 800-351-7500  Claims Center: 877-202-0055	<a href="http://www.mybenefits.reliancematrix.com/act">www.mybenefits.reliancematrix.com/act</a>

# Annual 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%<sup>1</sup> 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.<sup>1,2</sup>

**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](https://www.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](https://www.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 the Benefits Team at [benefits@act.org](mailto:benefits@act.org). The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1. Indexed annually; see [irs.gov/pub/irs-drop/rp-22-34.pdf](https://www.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: the Benefits Team at [benefits@act.org](mailto:benefits@act.org).

## 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

To the extent that we have your substance use disorder patient records, subject to 42 CFR part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.

## 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, office, or mobile 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,” for example, if it could affect your care. If we agree to your request, we may still share this information in the event that you need emergency treatment.

### 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 someone has authority to act as your personal representative, such as if someone has your 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/](http://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. And in all cases, if we have substance use disorder patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, administrative, or legislative investigations or proceedings against you without (1) your consent or (2) a court order and a subpoena.

#### **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 in this notice 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](http://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.

Other Instructions for Notice

- Notice is effective February 16, 2026
- For questions or concerns, please contact: Kimm Gilmore at 319-341-2283 or [kimm.gilmore@act.org](mailto:kimm.gilmore@act.org).

## Important Notice from ACT Education Corp. 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 ACT Education Corp. 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. ACT Education Corp. has determined that the prescription drug coverage offered by the ACT Group Medical 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 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 ACT Education Corp. 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 ACT Education Corp. 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](http://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](http://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: 01/01/2026

Name of Entity/Sender: ACT Education Corp.

Contact--Position/Office: Kimm Gilmore/Program Director, Total Rewards

Address: 500 ACT Drive, Iowa City, IA 52243

Phone Number: 319-341-2283

## 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. If you would like more information on WHCRA benefits, call your plan administrator at 319-341-2283.

#### **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 319-341-2283 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 balance billed for these post-stabilization services.

##### **Certain services at an in-network hospital or ambulatory surgical center**

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

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

**You’re never required to give up your 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.

Visit [www.cms.gov](http://www.cms.gov) for more information about your rights under federal law.

Visit [www.iid.iowa.gov](http://www.iid.iowa.gov) for more information about your rights under Iowa Law.

## **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](http://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](http://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](http://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
<b>Alabama</b> Medicaid	<a href="http://myalhipp.com">myalhipp.com</a>	855-692-5447
<b>Alaska</b> Medicaid	Premium Payment Program: <a href="http://myakhipp.com">myakhipp.com</a> Medicaid Eligibility: <a href="http://health.alaska.gov/dpa">health.alaska.gov/dpa</a> Email: <a href="mailto:customerservice@myakhipp.com">customerservice@myakhipp.com</a>	866-251-4861
<b>Arkansas</b> Medicaid	<a href="http://myarhipp.com/">http://myarhipp.com/</a>	855-MyARHIPP (855-692-7447)
<b>California</b> Medicaid	<a href="http://dhcs.ca.gov/hipp">dhcs.ca.gov/hipp</a> Email: <a href="mailto:hipp@dhcs.ca.gov">hipp@dhcs.ca.gov</a>	916-445-8322 916-440-5676 (fax)
<b>Colorado</b> Medicaid and CHIP	Medicaid: <a href="http://healthfirstcolorado.com">healthfirstcolorado.com</a> CHIP: <a href="http://hcpf.colorado.gov/child-health-plan-plus">hcpf.colorado.gov/child-health-plan-plus</a> HIBI: <a href="http://mycohibi.com">mycohibi.com</a>	800-221-3943 Relay 711 800-359-1991 Relay 711 855-692-6442
<b>Florida</b> Medicaid	<a href="http://flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html">flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html</a>	877-357-3268
<b>Georgia</b> Medicaid	HIPP: <a href="http://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a> CHIPRA: <a href="http://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra">medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra</a>	678-564-1162, press 1 678-564-1162, press 2
<b>Indiana</b> Medicaid	HIPP: <a href="https://www.in.gov/fssa/dfr/">https://www.in.gov/fssa/dfr/</a> All other Medicaid: <a href="http://in.gov/medicaid">in.gov/medicaid</a>	800-403-0864 800-457-4584
<b>Iowa</b> Medicaid and CHIP	Medicaid: <a href="http://hhs.iowa.gov/programs/welcome-iowa-medicaid">hhs.iowa.gov/programs/welcome-iowa-medicaid</a> CHIP: <a href="http://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki">hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki</a> HIPP: <a href="http://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp">hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp</a>	800-338-8366 800-257-8563 888-346-9562

<b>Kansas</b> Medicaid	<a href="http://kancare.ks.gov">kancare.ks.gov</a>	800-792-4884 HIPP: 800-967-4660
<b>Kentucky</b> Medicaid and CHIP	KI-HIPP: <a href="http://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a> KI-HIPP Email: <a href="mailto:KIHIPPPROGRAM@ky.gov">KIHIPPPROGRAM@ky.gov</a> KCHIP: <a href="http://kynect.ky.gov">kynect.ky.gov</a> Medicaid: <a href="http://chfs.ky.gov/agencies/dms">chfs.ky.gov/agencies/dms</a>	KI-HIPP: 855-459-6328 KCHIP: 877-524-4718
<b>Louisiana</b> Medicaid	<a href="http://ldh.la.gov/healthy-louisiana">ldh.la.gov/healthy-louisiana</a> or <a href="http://www.ldh.la.gov/lahipp">www.ldh.la.gov/lahipp</a>	Medicaid: 888-342-6207 LaHIPP: 855-618-5488
<b>Maine</b> Medicaid	Enrollment: <a href="http://mymaineconnection.gov/benefits">mymaineconnection.gov/benefits</a> Private health insurance premium: <a href="http://maine.gov/dhhs/ofi/applications-forms">maine.gov/dhhs/ofi/applications-forms</a>	Enroll: 800-442-6003 Private HIP: 800-977-6740 TTY/Relay: 711
<b>Massachusetts</b> Medicaid and CHIP	<a href="http://mass.gov/masshealth/pa">mass.gov/masshealth/pa</a> Email: <a href="mailto:masspremassistance@accenture.com">masspremassistance@accenture.com</a>	800-862-4840 TTY/Relay: 711
<b>Minnesota</b> Medicaid	<a href="http://mn.gov/dhs/health-care-coverage">mn.gov/dhs/health-care-coverage</a>	800-657-3672
<b>Missouri</b> Medicaid	<a href="http://dss.mo.gov/mhd/participants/pages/hipp.htm">dss.mo.gov/mhd/participants/pages/hipp.htm</a>	573-751-2005
<b>Montana</b> Medicaid	HIPP: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a> HIPP Email: <a href="mailto:HHSHIPPPProgram@mt.gov">HHSHIPPPProgram@mt.gov</a>	800-694-3084
<b>Nebraska</b> Medicaid	<a href="http://ACCESSNebraska.ne.gov">ACCESSNebraska.ne.gov</a>	855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
<b>Nevada</b> Medicaid	Medicaid: <a href="http://dhcnp.nv.gov">dhcnp.nv.gov</a>	800-992-0900
<b>New Hampshire</b> Medicaid	<a href="http://dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program">dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program</a> Email: <a href="mailto:DHHS.ThirdPartyLiabi@dhhs.nh.gov">DHHS.ThirdPartyLiabi@dhhs.nh.gov</a>	603-271-5218 or 800-852-3345, ext. 15218
<b>New Jersey</b> Medicaid and CHIP	Medicaid: <a href="http://state.nj.gov/humanservices/dmahs/clients/medicaid">state.nj.gov/humanservices/dmahs/clients/medicaid</a> CHIP: <a href="http://njfamilycare.org/index.html">njfamilycare.org/index.html</a>	Medicaid: 800-356-1561 CHIP Premium Assist: 609-631-2392 CHIP: 800-701-0710 TTY/Relay: 711
<b>New York</b> Medicaid	<a href="http://health.ny.gov/health_care/medicaid">health.ny.gov/health_care/medicaid</a>	800-541-2831

<b>North Carolina</b> Medicaid	<a href="https://www.medicaid.ncdhhs.gov">medicaid.ncdhhs.gov</a>	919-855-4100
<b>North Dakota</b> Medicaid	<a href="https://hhs.nd.gov/healthcare">hhs.nd.gov/healthcare</a>	844-854-4825
<b>Oklahoma</b> Medicaid and CHIP	<a href="https://insureoklahoma.org">insureoklahoma.org</a>	888-365-3742
<b>Oregon</b> Medicaid	<a href="https://healthcare.oregon.gov/Pages/index.aspx">healthcare.oregon.gov/Pages/index.aspx</a>	800-699-9075
<b>Pennsylvania</b> Medicaid and CHIP	Medicaid: <a href="https://pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html">pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html</a> CHIP: <a href="https://dhs.pa.gov/CHIP/Pages/CHIP.aspx">dhs.pa.gov/CHIP/Pages/CHIP.aspx</a>	Medicaid: 800-692-7462 CHIP: 800-986-KIDS (5437)
<b>Rhode Island</b> Medicaid and CHIP	<a href="https://eohhs.ri.gov">eohhs.ri.gov</a>	855-697-4347 or 401-462-0311 (Direct RIte)
<b>South Carolina</b> Medicaid	<a href="https://scdhhs.gov">scdhhs.gov</a>	888-549-0820
<b>South Dakota</b> Medicaid	<a href="https://dss.sd.gov">dss.sd.gov</a>	888-828-0059
<b>Texas</b> Medicaid	<a href="https://hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program">hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program</a>	800-440-0493
<b>Utah</b> Medicaid and CHIP	UPP: <a href="https://medicaid.utah.gov/upp/">medicaid.utah.gov/upp/</a> UPP Email: <a href="mailto:upp@utah.gov">upp@utah.gov</a> Adult Expansion: <a href="https://medicaid.utah.gov/expansion/">medicaid.utah.gov/expansion/</a> Utah Medicaid Buyout Program: <a href="https://medicaid.utah.gov/buyout-program/">medicaid.utah.gov/buyout-program/</a> CHIP: <a href="https://chip.utah.gov">chip.utah.gov</a>	UPP: 877-222-2542
<b>Vermont</b> Medicaid	<a href="https://dvha.vermont.gov/members/medicaid/hipp-program">dvha.vermont.gov/members/medicaid/hipp-program</a>	800-250-8427
<b>Virginia</b> Medicaid and CHIP	<a href="https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select">coverva.dmas.virginia.gov/learn/premium-assistance/famis-select</a> <a href="https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs">coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs</a>	Medicaid/CHIP: 800-432-5924
<b>Washington</b> Medicaid	<a href="https://hca.wa.gov">hca.wa.gov</a>	800-562-3022
<b>West Virginia</b> Medicaid and CHIP	<a href="https://dhhr.wv.gov/bms/">dhhr.wv.gov/bms/</a> <a href="https://mywvhipp.com/">mywvhipp.com/</a>	Medicaid: 304-558-1700 CHIP: 855-699-8447
<b>Wisconsin</b> Medicaid and CHIP	<a href="https://dhs.wisconsin.gov/badgercareplus/p-10095.htm">dhs.wisconsin.gov/badgercareplus/p-10095.htm</a>	800-362-3002
<b>Wyoming</b> Medicaid	<a href="https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility">health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility</a>	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](https://dol.gov/agencies/ebsa)  
866-444-EBSA (3272)

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
[cms.hhs.gov](https://cms.hhs.gov)  
877-267-2323, Menu Option 4, ext. 61565

### Patient Protection Notice

ACT Education Corp.'s Wellmark HMO medical plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Wellmark designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Wellmark at the number on the back of your ID card.

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

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