

american bank & trust

2027

EMPLOYEE BENEFITS





Benefits Resource: get help understanding the benefits being offered to you by American Bank & Trust! On this Microsite, you can find short videos explaining how each of your benefit plans work, detailed benefit overviews, convenient links to benefit vendor websites, who to contact if you have questions and so much more!

Go here for More Information: <https://americanbanktrustbenefits.com/> or scan the QR code above.



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



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

IMPORTANT MEDICARE NOTICE:

3 If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page **25** for Medicare Part D coverage information.

WELCOME!

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

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



OPEN ENROLLMENT: TAKE ACTION!

Monday, November 2 – Monday, November 16, 2026

This Open Enrollment is an active enrollment, meaning all employees must enroll to have benefits in the new plan year. If you do not enroll, your benefits will be waived beginning January 1, 2027 and you will not be able to enroll until the next Open Enrollment unless you experience a Qualifying Life Event (QLE).

QUALIFYING LIFE EVENTS

Your benefit elections made during Open Enrollment will be effective January 1, 2027. You may not make changes to your elections unless you experience a qualifying life event, including change in legal marital status (marriage, divorce, death of spouse), change in dependents (birth, adoption), change in employment status (termination, part-time), or if you gain/lose coverage elsewhere.

IMPORTANT

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

Contact Kelli Ruggeberg or log in to Paycom to process a Qualifying Life Event.



BENEFITS ELIGIBILITY

BENEFIT ELIGIBILITY

You and your eligible family members may participate in the 2027 employee benefits program if you're a regular, full-time employee working a minimum of 30 hours per week.



DEPENDENT ELIGIBILITY

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

- Your legal spouse (includes common law)
- Children under the age of 26 regardless of student, dependency or marital status
- Children over age 26 who are listed on your federal tax return as fully dependent on you for support due to a mental or physical disability

NEW-HIRE ELIGIBILITY

- If you're new to American Bank & Trust, your benefits will begin on the first day of the month following 30 days of employment.

WHEN BENEFITS END

- The Coverage you elect will end if you drop benefits during the next Open Enrollment, drop benefits due to a qualifying event or your employment with American Bank & Trust is terminated for any reason.

PRE-TAX CONTRIBUTIONS

- Any medical, dental and vision contributions made for you and/or your tax-qualified dependents will be deducted from your pay on a pre-tax basis.

CHANGING BENEFITS AFTER ENROLLMENT

Qualified Life Event		Documentation Needed
Change in Marital Status	Marriage	Copy of marriage certificate
	Divorce/legal separation	Copy of divorce decree
	Death	Copy of death certificate
Change in Number of Dependents	Birth or adoption	Copy of birth certificate or copy of legal adoption papers
	Stepchild	Copy of birth certificate plus a copy of the marriage certificate between employee and spouse
	Death	Copy of death certificate
Change in Employment	Change in your eligibility status (i.e., full-time to part-time)	Notification of increase or reduction of hours that changes coverage status
	Change in spouse's benefits or employment status	Notification of spouse's employment status that results in a loss or gain of coverage

AMERICAN BANK & TRUST BENEFITS OVERVIEW

How to Enroll

1. **Understand Your Choices**—This booklet, as well as additional benefit information available to you, are very useful materials to help you make your decisions. Keep this information handy so you can refer to it throughout the year.
2. **Review Your Options with Your Family**—Make sure you include any other individuals who will be affected by your elections in the decision-making process.
3. **Make Your Elections on Paycom**—Make your elections by **Monday, November 16th** for this year's open enrollment.
<https://www.paycomonline.net>

Human Resources Contact for Benefit Questions:

Kelli Ruggeberg, hr@goambank.com or 563-441-6584

BENEFIT CUSTOMER SERVICE INFORMATION

Benefit	Phone	Website
Health & Pharmacy Benefits	800-258-1415	www.bankers-ins.com
Dental Benefits	800-544-0718	www.deltadentalia.com
Vision Benefits	800-828-9341	www.avesis.com
Flexible Spending Account Benefits	217-531-9000	https://chard.lh1ondemand.com
Health Savings Account Benefits	563-441-6584	Kelli Ruggeberg (HR In House)
Life, Disability, Critical Illness & Accident Benefits	800-877-5176	www.mutualofomaha.com
Retirement Savings Benefits	800-716-3742	www.go-retire.com

MEDICAL COMPARISON

Medical & Pharmacy Benefits - Iowa Bankers & Wellmark BCBS of Iowa

	Silver Plan Alliance Select		Bronze Plan Alliance Select	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (Calendar Year Deductibles)				
Individual	\$3,500	\$3,500	\$5,500	\$5,500
Family	\$7,000	\$7,000	\$11,000	\$11,000
Out of Pocket Maximum				
Individual	\$3,500	\$3,500	\$5,500	\$5,500
Family	\$7,000	\$7,000	\$11,000	\$11,000
Coinsurance				
Coinsurance	0%	0%	0%	0%
Preventive Care	No Charge	Deductible, 0%	No Charge	Deductible, 0%
Primary Care Visit	Deductible, 0%	Deductible, 0%	Deductible, 0%	Deductible, 0%
Specialist	Deductible, 0%	Deductible, 0%	Deductible, 0%	Deductible, 0%
Urgent Care	Deductible, 0%	Deductible, 0%	Deductible, 0%	Deductible, 0%
Virtual Visit	Deductible, 0%	Deductible, 0%	Deductible, 0%	Deductible, 0%
Chiropractic Services	Deductible, 0%	Deductible, 0%	Deductible, 0%	Deductible, 0%
Emergency Services	Deductible, 0%	Deductible, 0%	Deductible, 0%	Deductible, 0%
Diagnostic Testing	Deductible, 0%	Deductible, 0%	Deductible, 0%	Deductible, 0%
Imaging	Deductible, 0%	Deductible, 0%	Deductible, 0%	Deductible, 0%
Inpatient Facility	Deductible, 0%	Deductible, 0%	Deductible, 0%	Deductible, 0%
Outpatient Facility	Deductible, 0%	Deductible, 0%	Deductible, 0%	Deductible, 0%
Mental Health	Deductible, 0%	Deductible, 0%	Deductible, 0%	Deductible, 0%

MEDICAL COVERAGE

Medical & Pharmacy Benefits - Iowa Bankers & Wellmark BCBS of Iowa

EMPLOYEE'S MONTHLY PREMIUM

\$3,500/\$7,000 HDHP	
Employee	\$163.18
Employee/ Child(ren)	\$460.04
Family	\$992.04
\$5,500/\$11,000 HDHP	
Employee	\$6.38
Employee/ Child(ren)	\$377.28
Family	\$813.12

EMPLOYER HSA CONTRIBUTION MATCH*

	\$3,500/\$7,000 HDHP	\$5,500/\$11,000 HDHP
Employee	\$50	\$0
Employee/Child(ren)	\$65	\$65
Family	\$80	\$80

*You must also contribute to receive up to the monthly contribution match.



DENTAL PLAN

- To find an in-network provider visit www.deltadentalia.com
- Click on “Find a Dentist”
 - Select your specialty
 - Select your plan (Delta Dental PPO)
 - Contact customer service for further assistance

IOWA BANKERS & DELTA DENTAL OF IOWA

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

In-Network Plan Features Calendar Year Deductible	PPO	Premier/ Out of Network
Individual	\$15	\$25
Family	\$45	\$75
Annual Benefit Maximum	\$1,500	
Orthodontics Lifetime Maximum	\$2,000	
DIAGNOSTIC & PREVENTION Check-ups, teeth cleaning, x-rays, fluoride, sealants (See SPD for detailed info)	0%	0%
ROUTINE & RESTORATIVE Cavity repair, tooth extractions, general anesthesia/sedation, restoration of decayed or fractured teeth, routine oral surgery (See SPD for detailed info)	Deductible, 10%	Deductible, 20%
ENDODONTIC & HIGH COST RESTORATIONS (Endodontic) Root canals & therapy, apicoectomy, direct pulp cap, retrograde fillings (High Cost Restorations) Cast restorations – crowns, inlays, onlays, posts, cores (See SPD for detailed info)	Deductible 20%	Deductible 20%
PERIODONTAL Conservative procedures (non-surgical) & maintenance therapy Complex procedures (surgical) (See SPD for detailed info)	Deductible 20% Deductible 50%	Deductible 20% Deductible 50%
PROSTHETICS Bridges, dentures, implants (See SPD for detailed info)	Deductible 50%	Deductible 50%
ORTHODONTICS (Deductible Waived) (includes adult orthodontics)	50%	50%

Monthly Premium	
EMPLOYEE ONLY	\$44
EMPLOYEE + CHILD(REN)	\$94
FAMILY	\$129

- Included Enhancements (see HR for more information):
- Annual Maximum Carry Over (To Go) – allows carry over of a portion of unused Annual Benefit Maximums to the next benefit year
 - Enhanced Benefits Program – allows additional benefits for members with designated dental or medical conditions
 - CheckUp Plus – diagnostic and preventive dental services do not count towards the annual benefit maximum

VISION PLAN

AVESIS

Your vision insurance is provided by Avesis and entitles you to specific eye care benefits. Our policy covers routine eye exams and other procedures. It provides specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses. To find an in-network provider, please visit www.Avesis.com.



	In Network	Out of Network
Copays		
Routine Exam	\$10 Copay	Up to \$35
Materials	\$25 Copay	See Below
Frequency		
Comprehensive Eye Exam	Once Every 12 Months	
Lenses/Contact Lenses	Once Every 12 Months	
Frames	Once Every 12 Months	
Lens Materials & Frames		
Frames	\$50-\$150	Up to \$45
Conventional Contact Lenses	Up to \$130	Up to \$110
Medically Necessary Contact Lenses	No Charge	Up to \$250
Single Vision Lenses	\$25 Copay	Up to \$25
Bifocal Lenses	\$25 Copay	Up to \$40
Trifocal Lenses	\$25 Copay	Up to \$50
Lenticular Lenses	\$25 Copay	Up to \$80
Standard Progressive Lenses	Save up to 20% off Retail, Plus a \$50 Allowance	Up to \$40
L3 Package Additions		
Youth/Adult Polycarbonate	\$25 Copay	Up to \$10
Standard Tint	\$25 Copay	Up to \$4
Standard Scratch-Resistant Coating	\$25 Copay	Up to \$5
Ultra-Violet Screening	\$25 Copay	Up to \$6
Standard Anti-Reflective Coating	\$25 Copay	Up to \$24
Monthly Premium		
EMPLOYEE ONLY	\$10.11	
EMPLOYEE + SPOUSE	\$19.33	
EMPLOYEE + CHILD(REN)	\$21.08	
FAMILY	\$28.43	

HEALTH SAVINGS ACCOUNT (HSA)

In House – American Bank & Trust

WHAT IS A HEALTH SAVINGS ACCOUNT?

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

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

WHO IS ELIGIBLE FOR AN HSA?

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

QUALIFIED HEALTHCARE EXPENSES YOU CAN SAVE ON:

Medical treatments
Physical therapy
Chiropractic treatments
Acupuncture
Emergency services
Medically prescribed Rx

Dental treatments
Vision treatments
Fertility enhancements
Hearing aids
Lab fees
Psychiatric care

Speech therapy
Stop-smoking programs
Vasectomy
Wheelchairs
X-rays
Birth control pills

Long term care premium
Some Medicare premium
COBRA premium

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



HEALTH SAVINGS ACCOUNT (HSA) (CONT.)

HSAs AND YOUR TAXES

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

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

MISTAKEN DISTRIBUTIONS

If you withdraw money to pay an expense that you reasonably but mistakenly believed to be a qualifying medical expense, you can avoid tax consequences by returning the funds to the HSA before April 15th of the year after you discovered the mistake. If not, your distribution will receive a 20% tax penalty.

HOW MUCH CAN I CONTRIBUTE?

- Employee only coverage: **\$4,500** per calendar year
- Employee plus dependents coverage: **\$9,000**
- If you are 55 or older, you can make an additional annual catch-up contribution of **\$1,000**



FLEXIBLE SPENDING ACCOUNT (FSA)

Chard Snyder Benefit Solutions

HEALTH CARE FSA

This program lets you pay for certain IRS approved medical care expenses not covered by your insurance plan with pre-tax dollars. Some examples include medical expenses, vision expenses, dental expenses, acupuncture, chiropractic care, deductible, coinsurance, and copayments. Please visit the IRS website for a full list of qualified medical expenses.

Who can participate?

Employees who are not enrolled in the high deductible health plan.

What are the contribution limits?

Employees can contribute up to **\$3,400** in 2026.

What happens at the end of the year?

A balance of more than \$500 will be forfeited at the end of the year. However, any remaining balance under \$500 can be used the following plan year once funds are rolled over. Estimate your contributions carefully so you can avoid losing money.

Expenses need to be submitted for reimbursement by the end of March.

LIMITED PURPOSE FSA

This program lets you pay for eligible dental and vision expenses only. By limiting FSA reimbursements to dental and vision expenses, this program will not disqualify your eligibility.

Who can participate?

Employees enrolled in either of the high-deductible health plans.

What are the contribution limits?

Employees can contribute up to **\$3,400** for 2026.

You can use the funds for any qualified dental or vision expenses. No medical plan co-pays, deductibles, prescription drugs or alternative healthcare are eligible expenses through a LP-HFSA.

What happens at the end of the year?

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

DEPENDENT CARE FSA

Who can participate?

Any employee.

What are the contribution limits?

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

What happens at the end of the year?

This program enables you to pay for out-of-pocket, work related dependent day-care expenses with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single employees can also use the account. For DCAP expenses, generally an eligible child must be under the age of 13 and share your same principal residency for more than half the year. Under a special rule for DCAP expenses for children of divorced or separated parents, a child is an eligible dependent with respect to the custodial parent even when the noncustodial parent is entitled to claim the dependency exemption for the child.

WHAT'S AN ELIGIBLE EXPENSE?

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

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



HSA & FSA COMPARISON

This chart shows the features of the healthcare FSAs and the Health Savings Account (HSA) and compares the limited purpose healthcare FSA to the traditional healthcare FSA.



	Health Savings Account	Limited Purpose Health Care FSA*	Health Care FSA **
Available if you select	High-deductible Health Plan	High-deductible Health Plan	Traditional PPO
How much you may contribute	\$4,500 (EE only) \$9,000 (all other coverage levels) Catch-up contributions of up to \$1,000 for 2027 year for age 55+	Up to \$3,400 for plan year 2026	
Account balance available to reimburse expenses	Current account balance	Entire contribution amount elected for the plan year	
Time limits for using your account balance	No limit	Must use 2027 account balance for expenses incurred through the plan year. Claims must be filed by no later than 90 days after the end of the plan year.	
If you don't use all your account balance each year	Any account balance carries over from year-to-year	You must submit claims by 90 days after the plan year, \$500 can carry over to the 2026 new year.	
How it saves you money	Your contributions are tax free, which reduces your taxable income Any investment or interest earnings on your account balance is tax free Distributions are tax free if used for qualified healthcare expenses	Your contributions are tax-free, which reduces your taxable income and increases your take-home pay You pay for healthcare expenses with pre-tax dollars	
Expenses you may pay from your account	Out-of-pocket Medical Prescription drug Dental Vision	Out of pocket expenses incurred during the current calendar year	
		Dental Vision	Medical Prescription drugs Dental Vision

* The limited purpose FSA is available to employees who enroll in our HDHP. HDHP members may not enroll in the healthcare FSA, unless you are ineligible to participate in the HSA.

** You don't have to participate in a company medical plan to enroll in a healthcare FSA.

LIFE INSURANCE



Mutual of Omaha

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

The Basic Life and AD&D plan provides a benefit in the event of your death, dismemberment or paralysis. This benefit is sponsored by American Bank & Trust, so you will automatically be enrolled at no cost to you. Your coverage will be 2 times your annual earnings, rounded to the next higher \$1,000 (no less than \$10,000 and no more than \$250,000).

Your benefits will reduce starting at age 65

- Age 65: 65% of the Benefit
- Age 70: 40% of the Benefit
- Age 75: 25% of the Benefit

If you become totally disabled while you are insured for continuation eligible insurance under this policy, you may qualify to continue certain insurance. If continued, premium payment will not be required. Mutual of Omaha will determine if you qualify for this continuation after they receive proof you have satisfied conditions.

If you become terminally ill, you have the option to request an accelerated benefit option before your death. Terminally ill means due to a sickness or injury, you are expected to die within 12 months.

You have the option to apply to convert this policy into individual coverage upon termination of employment.

VOLUNTARY TERM LIFE BENEFITS

	Employee Coverage Options	Spouse Coverage Options	Child(ren) Coverage Options
MULTIPLES OF MINIMUM ELECTION GUARANTEE ISSUE MAXIMUM ELECTION	\$10,000	\$5,000	\$2,000-\$10,000
	\$10,000	\$5,000	\$2,000
	5x Salary to \$150,000	100% of EE Amount to \$30,000	\$10,000
	5x Salary to \$500,000	100% of EE Amount to \$100,000	\$10,000
	\$10,000	\$50,000	\$100,000
BASED ON EMPLOYEE AGE			
UNDER 30 (\$0.084)	\$0.84	\$4.20	\$8.40
30-34 (\$0.103)	\$1.03	\$5.15	\$10.30
35-39 (\$0.116)	\$1.16	\$5.80	\$11.60
40-44 (\$0.157)	\$1.57	\$7.85	\$15.70
45-49 (\$0.227)	\$2.27	\$11.35	\$22.70
50-54 (\$0.339)	\$3.39	\$16.95	\$33.90
55-59 (\$0.577)	\$5.77	\$28.85	\$57.70
60-64 (\$0.801)	\$8.01	\$40.05	\$80.10
65-69 (\$1.387)	\$13.87	\$69.35	\$138.70
70+ (\$2.237)	\$22.37	\$111.85	\$223.70
CHILD COVERAGE (\$0.20)	\$2K=\$0.40, \$3K=\$0.60, \$4K=\$0.80, \$5K=\$1.00, \$6K=\$1.20, \$7K=\$1.40, \$8K=\$1.60, \$9K=\$1.80, \$10K=\$2.00		



STATEMENT OF HEALTH: A statement of health is required during open enrollment to elect voluntary term life benefits if:

- You don't already have this coverage.
- You already have coverage **AND** you want to increase your coverage by more than one \$10,000 increment. You may increase your coverage by one \$10,000 increment without a statement of health as long as the new increment does not cause your new coverage to exceed the guarantee issue amount. Spouse and child voluntary term life are not eligible for this annual increase without completing a statement of health. Fill out a statement of health here: www.mutualofomaha.com/eoi (enter "G000BMPN" in the group ID section).

DISABILITY INSURANCE

Mutual of Omaha

At American Bank & Trust we want to do everything we can to protect you and your family. That's why American Bank & Trust offers short- and long-term disability insurance. Both short-term disability and long-term disability are paid for by you.

In the event that you become disabled from a non-work-related injury or sickness, disability income benefits will provide a partial replacement of lost income. Please note that you are not eligible to receive short-term disability benefits if you are receiving workers' compensation benefits.



	Voluntary Short Term Disability	Voluntary Long Term Disability
Elimination Period	Day of Accident / 8 th Day of Illness	STD Exhaustion or 180 days whichever is greater
Benefit	60% of before tax weekly earning	60% of before tax monthly earning
Maximum Benefit Period	Up to 26 Weeks	\$5,000/Month
Maximum Benefit	\$1,000/Week	\$5,000/Month
Minimum Benefit	\$25/Week	\$100/Month
Pre Existing Time Period	Any condition medical attention has been sought in the 3 months prior to initial enrollment and results in disability during the first 6 months of coverage would not be covered until this time period expires	Any condition medical attention has been sought in the 3 months prior to initial enrollment and results in disability during the first 12 months of coverage would not be covered until this time period expires
Own Occupation Period	N/A	First 24 months of long-term disability
Extra Service	Hearing Discount Program www.amplifonusa.com/mutualofomaha or (888) 534-1747	

STD PREMIUM*

	Premium Factor	Example Weekly Earning \$769.23 (~\$40,000 Annual)	Example Weekly Earning \$1,250 (~\$65,000 Annual)	Example Weekly Earning \$1,667.67 (~\$86,500 Annual)
		Monthly Premium		
	.045	\$34.62	\$56.25	\$75.05

LTD PREMIUM*

	Premium Factor	Example Monthly Earning \$3,333.33 (~\$40,000 Annual)	Example Monthly Earning \$5,416.66 (~\$65,000 Annual)	Example Monthly Earning \$8,333.33 (~\$100,000 Annual)
BASED ON EMPLOYEE AGE		Monthly Premium		
UNDER 24	.0004	\$1.33	\$2.17	\$3.33
25-29	.0008	\$2.67	\$4.33	\$6.67
30-34	.0012	\$4.00	\$6.50	\$10.00
35-39	.0016	\$5.33	\$8.67	\$13.33
40-44	.0023	\$7.67	\$12.46	\$19.17
45-49	.0029	\$9.67	\$15.71	\$24.17
50-54	.0034	\$11.33	\$18.42	\$28.33
55-59	.0048	\$16.00	\$26.00	\$40.00
60-64	.0053	\$17.67	\$28.71	\$44.17
65-69	.0059	\$19.67	\$31.96	\$49.17
70+	.0068	\$22.67	\$36.83	\$56.67

You can contact Mutual of Omaha by phone, website, or through the app.

*See Benefit Admin System for exact monthly premium.

16 STATEMENT OF HEALTH: A statement of health is not required during your initial enrollment of long-term disability benefit. Fill out a statement of health here: www.mutualofomaha.com/eoi (enter "G000BMPN" in the group ID section).

EMPLOYEE ASSISTANCE PROGRAM (EAP)

We understand that we all face serious problems at some time in our lives and American Bank & Trust is committed to providing help during those times.

The EAP is designed to assist staff members and families with personal challenges in many different areas including: depression, stress management, drug and alcohol abuse, relationships, grief, domestic violence, legal and financial issues, parenting, childcare and elder care.

We're Here to Help

Mutual of Omaha's EAP assists employees and their eligible dependents with personal or job-related concerns, including:

- Emotional well-being
- Family and relationships
- Legal and financial matters
 - Healthy lifestyles
- Work and life transitions

EAP Benefits

- Access to EAP professionals 24/7/365 who can provide information and referral resources
 - Service for employees and eligible dependents
 - Robust network of licensed mental health professionals
- 3 face-to-face sessions with a counselor (per household per calendar year)
 - Legal assistance & Financial Resources
 - Online will preparation
 - Legal library & online forms
 - Financial tools and resources
 - Resources for substance abuse and other addictions, dependent and elder care
- Access to a library of educational articles, handouts, and resources via www.mutualofomaha.com/eap

What to Expect

- You can trust your EAP professional to assess your needs and handle your concerns in a confidential, respectful manner. Our goal is to collaborate with you and find solutions that are responsive to your needs.
- Your EAP benefits are provided through American Bank & Trust. There is no cost to you for utilizing EAP services. If additional services are needed, your EAP professional will help locate appropriate resources in your area.



**24 HOURS A DAY,
7 DAYS A WEEK**

Visit:

www.mutualofomaha.com/eap
or call 800-316-2796 for a
confidential consultation and
resource services



CRITICAL ILLNESS INSURANCE



Mutual of Omaha

	Employee Coverage Options	Spouse Coverage	Child(ren) Coverage
MULTIPLES OF MINIMUM ELECTION	\$5,000		
GUARANTEE ISSUE	\$5,000	100% of Employee's Benefit up to \$15,000	50% of Employee's Benefit up to \$3,000
MAXIMUM ELECTION	\$15,000		
	\$30,000		

OVERVIEW

A lump sum benefit is payable if you or your covered dependents are diagnosed with any of the following critical illnesses while this insurance is in effect, after any applicable waiting period and subject to any pre-existing condition limitation. The critical illness insurance amount is referred to as the CI Principal Sum. For some critical illnesses, 100% of the sum is payable, and for others, a partial benefit (a lesser percentage of the sum) is payable.

ANNUAL HEALTH SCREENING

A health screening benefit of **\$50** is payable once per calendar year for each insured person who has a health screening test performed while insurance is in effect.

COVERED CRITICAL ILLNESSES

Heart attack, heart transplant, stroke, ALS, advanced Alzheimer's, advanced Parkinson's, major organ transplant, end-stage renal failure, and cancer (invasive)

Childhood/Development CI: cerebral palsy, structural congenital defects, genetic disorders, congenital metabolic disorders, and type 1 diabetes

COVERED CRITICAL ILLNESSES AT A LESSER BENEFIT %

Heart valve surgery (25%), coronary bypass surgery (25%), aortic surgery (25%), ARDS (25%), bone marrow transplant (50%), carcinoma in situ (25%) and benign brain tumor (25%)

PRE-EXISTING CONDITIONS

Benefits are not payable for any critical illness caused by, attributable to or resulting from a pre-existing condition until 12 months after an insured person is continuously insured. A pre-existing condition includes any critical illness for which an insured person received treatment in the 12 months prior to the date the person became insured.

RECURRENCE BENEFIT & MAX

Once benefits have been paid for a critical illness for an insured person, a reoccurrence benefit is payable one time for a subsequent diagnosis of that same critical illness. The amount of the reoccurrence benefit is the lesser of 50% of the CI Principal Sum or the benefit shown above for the insured person, subject to a maximum of 300% of the Principal Sum. If the benefits reach the maximum, insurance for the insured person will terminate.

MONTHLY PREMIUM PER \$5,000 OF COVERAGE EXAMPLES

BASED ON EMPLOYEE AGE	\$5,000	\$15,000	\$30,000
UNDER 25 (\$1.90)	\$1.90	\$5.70	\$11.40
25-29 (\$2.05)	\$2.05	\$6.15	\$12.30
30-34 (\$2.75)	\$2.75	\$8.25	\$16.50
35-39 (\$3.80)	\$3.80	\$11.40	\$22.80
40-44 (\$5.65)	\$5.65	\$16.95	\$33.90
45-49 (\$8.35)	\$8.35	\$25.05	\$50.10
50-54 (\$11.80)	\$11.80	\$35.40	\$70.80
55-59 (\$16.20)	\$16.20	\$48.60	\$97.20
60-64 (\$23.15)	\$23.15	\$69.45	\$138.90
65-69 (\$34.65)	\$34.65	\$103.95	\$207.90
70-74 (\$53.55)	\$53.55	\$160.65	\$321.30
75-79 (\$82.90)	\$82.90	\$248.70	\$497.40
80-99 (\$173.25)	\$173.25	\$519.75	\$1,039.50
CHILD COVERAGE	Child insurance is automatic. A separate premium is not required.		

ACCIDENT BENEFITS OVERVIEW

Mutual of Omaha



ACCIDENT INSURANCE

Accident insurance pays out a lump sum if you become injured because of an accident off the job. While health insurance companies pay your provider or facility, accident insurance pays you directly.

How Does Accident Insurance Work?

Accident insurance policies can provide you with a lump sum paid directly to you that will help pay for a wide range of situations, including initial care, surgery, transportation and lodging and follow-up care. Here's how it works:

- A set amount is payable based on the injury you suffer and the treatment you receive
- Benefits are payable directly to you (unless you specify otherwise) and can be used as you see fit
- Coverage is available for you, your spouse and eligible dependent children
- You do not need to answer medical questions or have a physical exam to get basic coverage
- Benefit payments are not reduced by any other insurance you may have with other companies

Covered expenses typically include:

- Emergency room visits
- Hospital stays
- Fractures and dislocations
- Medical exams
- Physical therapy
- Transportation and lodging

ACCIDENT BENEFITS OVERVIEW (CONT.)

Mutual of Omaha

Annual Health Screening	A health screening benefit of \$50 is payable once per calendar year for each insured person who has a health screening test performed while insurance is in effect.		
Initial Care & Emergency Benefits	\$150 Emergency Room \$100 Urgent Care	\$75 Initial Physician Office Visit	\$200 Ground Ambulance \$1,000 Air Ambulance
Fractures (Open Reduction/ Closed Reduction)	\$6,000/\$3,000 Skull, Depressed \$3,000/\$1,500 Skull, Non-Depressed \$1,200/\$600 Bones of Face \$900/\$450 Nose \$1,200/\$600 Lower Jaw	\$900/\$450 Collarbone \$900/\$450 Rib \$1,200/\$600 Upper Arm or Forearm \$1,200/\$600 Wrist or Hand \$400/\$200 Fingers or Toes	\$3,000/\$1,500 Vertebral Body \$3,000/\$1,500 Pelvis \$6,000/\$3,000 Hip Bones \$1,200/\$600 Ankle or Foot
Dislocations (Reduction/ Closed Reduction)	\$1,800/\$900 Lower Jaw \$1,800/\$900 Shoulder or Collarbone	\$1,800/\$900 Wrist or Hand \$450/\$225 Fingers or Toe	\$9,000/\$4,500 Hip \$4,500/\$2,250 Kneecap or Foot
Lacerations	\$100 Less than 2 in. \$450 2 in. to 6 in.	\$800 Greater than 6 in. \$50 No Repair required	\$9,000/ \$4,500 Hip \$4,500/ \$2,500 Kneecap or Foot
Burns (TBSA= Total Body Surface Area)	\$250 2nd degree <=9% TBSA \$500 2nd degree 10-36% TBSA \$1,500 2nd degree >36% TBSA	\$2,000 3rd degree <18% TBSA \$7,500 3rd degree 18-36% TBSA \$15,000 3rd degree >36% TBSA	25% of Burn Benefit Skin Graft
Dental Care	\$300 Crown or Filling Repair	\$100 Extraction	
Hospital, Surgical & Diagnostic	\$1,000 Admission \$200 per day daily confinement (365 max) \$400 per day ICU confinement (15 max) \$100 per day rehab confinement (30 max)	\$150 Exploratory/Arthroscopic Surgery \$1,500 Abdominal/Cranial/Thoracic \$600 Herniated Disc \$300 Eye Procedure	\$50 X- Ray \$200 Diagnostic Exam \$150 Brain Injury Diagnosis
Follow- Up Care & Additional Benefits	\$75 Physician Follow- up Office Visit \$25 Therapy Services \$100 Medical Device	\$300 Transportation per trip (3 max) \$125 Lodging (30 night max) \$20 Childcare per day (30 max)	
Catastrophic Benefits	Accidental death principal sum: \$50,000 Employee \$25,000 Spouse \$10,000 Child(ren)	Dismemberment: 100% Loss of both hands, both feet, entire sight of both eyes 100% Loss of speech/loss of hearing	Paralysis: 100% Quadriplegia 50% Paraplegia 25% Uniplegia 25% Coma
Child Sports Injury Booster	10%		

Monthly Premium	
EMPLOYEE ONLY	\$7.91
EMPLOYEE + SPOUSE	\$11.93
EMPLOYEE + CHILDREN	\$28.95
FAMILY	\$37.25

STATEMENT OF HEALTH: A statement of health is not required during your initial enrollment of accident benefits.

AMERICAN BANK AND TRUST COMPANY

401(k) PROFIT SHARING PLAN HIGHLIGHTS

This is a summary of the plan features, for full details and to confirm the accuracy go to the Summary Plan Description

PLAN OVERVIEW

Plan administrator	American Bank and Trust Company, NA 4301 East 53rd Street, Davenport, IA 52807 (877) 626-2265
Participant support	Participant Service Center: (800) 716-3742 Monday through Friday, 8:00 a.m. to 8:00 p.m. ET Participant website: www.go-retire.com

ELIGIBILITY AND ENTRY

Eligible employees	All employees are eligible to participate upon reaching age 18.
Salary deferrals	No minimum service requirement.
Matching contributions	Three consecutive months of service.
Profit Sharing contributions	One Year of Service, during which you complete 1,000 hours of service.

CONTRIBUTIONS

Pre-tax and Roth deferrals	You may elect to defer up to 100% of Plan Compensation on a pre-tax basis, as Roth contributions on an after-tax basis, or as a combination, subject to applicable IRS limits. Elections may be changed each pay period.
Automatic enrollment	If you are eligible and do not make an election, 6% of Plan Compensation will be withheld each pay period as a pre-tax Salary Deferral. You may elect a different percentage, including 0%.
Changing or withdrawing an election	You may increase, decrease, or stop Salary Deferrals according to the Plan's election procedures. Automatically withheld contributions and related earnings may be withdrawn within 90 days after the first automatic deferral; associated matching contributions are forfeited.
Catch-up contributions	If you are age 50 or older, you may make catch-up contributions, subject to applicable federal limits.
Matching contributions	The Bank may, in its sole discretion, make a Matching Contribution on your behalf in an amount determined by the Bank.
Profit-sharing contributions	The Bank may, in its sole discretion, make a Profit-Sharing Contribution allocated as a uniform percentage of Plan Compensation. To receive a contribution for a Plan Year, you must complete at least 1,000 hours of service during that Plan Year and be employed by the Bank on the last day of the Plan Year.
Rollovers	The Plan may accept an eligible Rollover Contribution before you satisfy the Plan's age and service requirements. Until you otherwise become eligible, you are treated as a Participant only with respect to your Rollover Contribution Account.

VESTING

Always 100% vested	Salary Deferrals, Roth Deferrals, and Rollover Contributions are always 100% vested.
Bank contributions	Matching and profit-sharing contribution accounts vest according to the following schedule: <ul style="list-style-type: none">- 0-1 Years of Vesting Service: 0%- 2 years: 20%- 3 years: 40%- 4 years: 60%- 5 years: 80%- 6 or more years: 100%

Accelerated vesting

You become 100% vested upon death while employed, termination of employment due to disability, reaching Normal Retirement Age while employed, or termination of the Plan.

Vesting service

A year of Vesting Service is earned by completing at least 1,000 hours during the Plan Year.

INVESTMENTS AND ROLLOVERS

Investment direction

You may direct all Plan accounts among the available investment options. The Plan is intended to comply with ERISA Section 404(c). If you do not make an investment election, contributions are invested in the Plan default investment.

DISTRIBUTIONS AND WITHDRAWALS

After employment ends

Your vested account balance may be distributed within a reasonable period after employment ends. Available payment forms include a lump sum or installments. Automatic rollover rules may apply to vested balances of \$5,000 or less.

While still employed

Vested amounts may be available at age 59½, for qualifying hardship, or upon disability. Additional military-service distribution events apply to Salary Deferrals. Rollover Contributions may be withdrawn at any time.

Hardship

Hardship distributions are subject to Plan requirements. Generally, available loans and other distributions must be taken first. Contact the Plan Administrator for information about the applicable process and required documentation.

Death

A vested account is payable to the designated beneficiary. If no beneficiary is designated, the Plan's default beneficiary rules apply.

PARTICIPANT LOANS

Availability

Loans are permitted from vested pre-tax deferral, Roth deferral, and rollover accounts.

Limits

Minimum loan: \$1,000

Maximum outstanding loans: one

Maximum amount is generally the lesser of \$50,000 or 50% of the vested account balance, subject to Plan rules.

Interest and term

Interest is prime plus 1 percentage point. The repayment period may not exceed five years, including loans used to purchase a principal residence.

Employment termination

An outstanding loan generally becomes due and payable when employment ends. A direct rollover of the loan note is not permitted.

CURRENT PLAN FEES AND RESOURCES

Individual fees

The 2026 Investment and Fee Notice lists a \$100 fee for each of the following: lump-sum distributions, in-service distributions, hardship distributions, required minimum distributions, new-loan setup, installment payments by check or ACH, and QDRO processing. The fee for overnight mail delivery is \$50.

Online resources

Use www.go-retire.com to manage your account. The Retirement Education Center provides educational videos, retirement calculators, and investment information.

IMPORTANT: These highlights provide a concise overview and are not the legal Plan document or Summary Plan Description. If there is a conflict, the governing Plan document controls. Plan provisions, limits, investments, and fees may change. Contact the Plan Administrator for current information.

BENEFITS DEFINITIONS

DEDUCTIBLE

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible.)

COINSURANCE

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is \$100 and you've met your deductible, your coinsurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.)

OUT-OF-POCKET MAXIMUM

The most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit, the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover.

COPAYMENT

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service (sometimes called "copay"). The amount can vary by the type of covered health care service.

NETWORK

The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

NETWORK PROVIDER

A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

There is no first dollar coverage with the exception of preventative services.



PROVIDER

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

OUT-OF-NETWORK PROVIDER

A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider."

BENEFITS DEFINITIONS (CONT.)

REFERRAL

A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you may need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

PREMIUM

You typically pay premiums through payroll deductions.

HIGH-DEDUCTIBLE HEALTH PLAN (HDHP)

A type of health plan that has lower monthly premiums, but higher deductibles and out-of-pocket limits, than a traditional health plan. HDHPs are often coupled with an HSA (Health Savings Account).



EMPLOYEE NOTICES

IMPORTANT NOTICE FROM AMERICAN BANK & TRUST ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE FOR YOUR MEDICAL PLAN

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with American Bank & Trust 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. American Bank & Trust has determined that the prescription drug coverage offered by American Bank & Trust's plans 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 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide To Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current American Bank & Trust coverage may be affected. If you do decide to join a Medicare drug plan and drop your current American Bank & Trust coverage, be aware that you and your dependents may not 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 American Bank & Trust 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 November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. 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 American Bank & Trust 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: 1/1/2027
Name of Entity/ Sender: American Bank & Trust Company, N/A
Contact: Kelli Ruggeberg
Address: 4301 E 53rd St, Davenport IA 52807
Phone Number: 563-441-6584

HIPAA SPECIAL ENROLLMENT NOTICE

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

Loss of Other Coverage (including Medicaid and State Child Health Coverage)

If you are declining coverage for yourself or your dependents (including spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage. Some plans may allow longer than 30 days, so please refer to your plan documents for your specific plan details.

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

Marriage, Birth or Adoption

If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption. Some plans may allow longer than 30 days, so please refer to your plan documents for your specific plan details.

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

Medicaid or State Child Health Coverage

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

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

EMPLOYEE NOTICES

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;

- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to Human Resources.

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, Medicaid, 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 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.

EMPLOYEE NOTICES

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.

Contact Information
American Bank & Trust
4301 E 53rd St
Davenport, IA 52807
563-441-6584

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The sav-

ings on your premium that you're eligible for depends on your household income.

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 10.22% for plans that start in 2027 of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

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

How can I get more information?

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

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

WOMEN'S HEALTH & CANCER RIGHTS ACT OF 1998

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

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

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

EXPANDED COVERAGE FOR WOMEN'S PREVENTIVE

Under the Affordable Care Act, American Bank & Trust provides female participants with expanded access to recommended in-network preventive services, without cost sharing. Additional women's preventive services include: Well-woman visits, Gestational diabetes screen, HPV DNA testing, STI counseling and HIV screening and counseling, Contraception and Contraception counseling, Breast-feeding support, supplies and counseling and Domestic violence screenings. For a description of what these items include, visit: <https://www.healthcare.gov/preventive-care-women/>. Please see Human Resources for benefit details.

60-DAY SPECIAL ENROLLMENT PERIOD

In addition to the qualifying events listed in this document, you and your dependents will have a special 60-day period to elect or discontinue coverage if:

- You or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- You or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

NEWBORN AND MOTHERS HEALTH PROTECTION ACT

For maternity hospital stays, in accordance with federal law, the Plan does not restrict benefits, for any hospital length of stay in connection with childbirth for the mother or newborn child, to less than 48 hours following a vaginal delivery or less than 96 hours following a Cesarean delivery.

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

IOWA BANKERS BENEFIT PLAN – NOTICE OF PRIVACY PRACTICES

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.

This notice is provided to participants of Iowa Bankers' Benefit Plan ("Plan") and describes how the Plan and Iowa Bankers Insurance and Services ("IBIS"), as the administrator of the Plan, may use and disclose your protected health information. This notice also explains your rights and our obligations with respect to your protected health information. Throughout this notice references to "us," "we" or "our" shall refer to the Plan.

Protected Information. In the course of paying for health care services provided to you, information regarding your health care may be

EMPLOYEE NOTICES

originated and/or received by us. Information which can be used to identify you and which relates to your past, present or future medical condition, receipt of health care or payment for health care ("Protected Information") is protected by federal and state law.

Our Responsibilities. Federal law imposes certain obligations and duties upon us as a health plan with respect to your Protected Information. Specifically, we are required to:

- Provide you with notice of our legal duties and the health plan's policies regarding the use and disclosure of your Protected Information;
- Maintain the confidentiality of your Protected Information in accordance with state and federal law;
- Honor your requested restrictions regarding the use and disclosure of your Protected Information, if required by law to do so;
- Allow you to inspect and copy your Protected Information during our regular business hours;
- Act on your request to amend Protected Information within sixty (60) days and notify you of any delay which would require us to extend the deadline by the permitted thirty (30) day extension;
- Honor your requested restrictions regarding the use and disclosure of your Protected Information, unless under the law, the Plan is authorized to release your Protected Information without your authorization, in which case you will be notified within a reasonable period of time;
- 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 Protected Information;
- Accommodate reasonable requests to communicate Protected Information by alternative means or methods; and
- Abide by the terms of this notice and provide you with a copy of this notice at any time.

How Your Protected Information May be Used and Disclosed. Generally, your Protected Information may be used and disclosed by us only with your express written authorization. However, there are some exceptions to this general rule. The following are ways in which we may use or disclose your Protected Information without your written authorization.

Treatment, Payment, or Health Care Operations.

Treatment Purposes. We may use or disclose your Protected Information for treatment purposes. It may be necessary for us to communicate with health care providers providing treatment to you to facilitate that treatment. For example, your health care provider may request information regarding whether a particular treatment will be covered. Such information may be necessary for your provider to determine which course of treatment to prescribe.

Payment Purposes. Your Protected Information may also be used or disclosed for payment purposes. It is necessary for us to use or disclose Protected Information so that we may properly pay for treatment and services provided by your health care providers. For example, we may disclose infor-

mation regarding co-payments or coverage decisions over the phone to your spouse if necessary to facilitate payment of health care services provided to you. In addition, we may disclose information to other group health plans of which you are a participant if such information is necessary for their payment purposes. For example, we may disclose information to another group health plan of which you are a participant for their coordination of benefits or determination of whether they are liable for payment of a particular service.

Health Care Operations. Your Protected Information may also be used for health care operations, which are necessary for the management of the health plan and for proper payment of claims. For example, we may disclose information to our accountant if necessary for auditing purposes. We may at times remove information, which could identify you from your record to prevent others from learning who the specific patients are. In addition, we may release your Protected Information to another individual or entity covered by the federal privacy regulations that has a relationship with you for their fraud and abuse detection or compliance purposes, quality assessment and improvement activities, or review, evaluation or training of health care professionals or students.

Plan Administrative Functions. Limited information, such as enrollment and disenrollment information and summary health information, may be disclosed to your employer.

Persons Involved with Your Care or Payment for Care. We may disclose your Protected Information to family members or others that you identify as being involved in decisions about your health care or payment for your health care. Before doing so, we will provide you with an opportunity to object to such uses or disclosures or if you are not present we will disclose Protected Information that is directly relevant to the person's involvement with your care or payment related to your care if in the our professional judgment we determine it is in your best interest.

Authorized by Law. We may also use or disclose your protected health information without your authorization as permitted or required by law. Examples include: public health activities, health oversight activities, judicial and administrative proceedings, abuse reporting, law enforcement, workers compensation, organ donation, medical examiners and coroners, specialized government functions, to avert a serious threat to public health or safety, to comply with the law, and research purposes. Information will only be used/disclosed without your authorization as permitted by the applicable state or federal law.

More Stringent Laws. Some of your Protected Information may be subject to other laws and regulations and afforded greater protection than what is outlined in this Notice. For instance, HIV/AIDS, and mental health information are given more protection under Iowa law and substance abuse information is given more protection under federal law. In the event your Protected Information is afforded greater protection under federal or Iowa law, we will comply with the more stringent law.

Other uses and disclosures of Protected Information not covered by this Notice or the laws that apply to us will be made only with your written permission. For example, we need your written authorization to disclose your Protected Information to an attorney who represents you. In addition, we never sell your Protected Information or share it for marketing purposes unless you have given us written permission to do so. If you provide us permission to use or disclose Protected Information about you, you may revoke this permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose Protected Information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission. In no event will we use your genetic information to decide whether you are eligible for coverage or the cost of coverage.

Your Rights. Federal law grants you certain rights with respect to your Protected Information. Specifically, you have the right to:

- Receive notice of our policies and procedures used to protect your Protected Information;
- Request that certain uses and disclosures of your Protected Information be restricted; *provided, however*, if we may release the information without your consent or authorization, we have the right to refuse your request;
- Access to your Protected Information; *provided, however*, the request must be in writing and may be denied in certain limited situations;
- Request that your Protected Information be amended;
- Obtain an accounting of certain disclosures by us of your Protected Information for the past six years;
- Revoke any prior authorizations or consents for use or disclosure of Protected Information, except to the extent that action has already been taken;
- Request communications of your Protected Information are done by alternative means or at alternative locations; and
- Notification of any breach of unsecured Protected Information relating to you.

Important Contact Information. This notice has been provided to you as a summary of how we will use your Protected Information and your rights with respect to your Protected Information. If you have any questions or for more information regarding your Protected Information, please contact our office at 1-800-258-1415.

If you believe your privacy rights have been violated, you may file a complaint by contacting our office at 1-800-258-1415. You may also file a complaint with the Secretary of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington DC 20201. You may call 1-877-696-6775 or visit www.hhs.gov/ocr/privacy/hipaa/complaints/. There will be no retaliation for the filing of a complaint.

Effective Date. This notice is effective August 4, 2016. Please note, we reserve the right to revise this notice at any time. A current notice of our privacy practices may be obtained by contacting our office at 1-800-258-1415 or on our website at www.bankers-ins.com. If any revision to this notice is material, we will provide you a copy within 60 days of the revision.

EMPLOYEE NOTICES

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, 2026. Contact your State for more information on eligibility –

STATE	WEBSITE/EMAIL	PHONE
Alabama Medicaid	myalhipp.com	855-692-5447
Alaska Medicaid	The AK Health Insurance Premium Payment Program: myakhipp.com Email: customerservice@myakhipp.com Medicaid Eligibility: health.alaska.gov/dpa/Pages/default.aspx	866-251-4861
Arkansas Medicaid	http://myarhipp.com/	855-MyARHIPP (855-692-7447)
California Medicaid	HIPP Website: www.dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance/ Email: hipp@dhcs.ca.gov	Phone: 916-445-8322 Fax: 916-440-5676
Colorado Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	Health First Colorado Website: healthfirstcolorado.com CHP+: hcpf.colorado.gov/child-health-plan-plus Health Insurance Buy-In Program (HIBI): mycohibi.com	Health First Colorado: 800-221-3943 Relay 711 CHP+: 800-359-1991 Relay 711 HIBI: 855-692-6442
Florida Medicaid	Website: https://www.flmedicaidtplecovery.com/flmedicaidtplecovery.com/hipp/index.html	877-357-3268

Georgia Medicaid	GA HIPP: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp GA CHIPRA: medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra	GA HIPP: 678-564-1162, press 1 GA CHIPRA: 678-564-1162, press 2
Illinois Medicaid	Illinois Medicaid Premium Assistance Information Medicaid applicaiton website: abe.illinois.gov HIPP Email: mhfs.boc.hipp@illinois.gov	217-524-8268
Indiana Medicaid	HIPP: https://www.in.gov/fssa/dfr/ All other Medicaid: in.gov/medicaid	Family & Social Services: 800-403-0864 Member Services: 800-457-4584
Iowa Medicaid and CHIP (Hawki)	Medicaid: hhs.iowa.gov/programs/welcome-iowa-medicaid Hawki: hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki HIPP: hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp	Medicaid: 800-338-8366 Hawki: 800-257-8563 HIPP: 888-346-9562
Kansas Medicaid	Website: kancare.ks.gov	Medicaid: 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: KIHIPPPROGRAM@ky.gov KCHIP: kynect.ky.gov Medicaid: chfs.ky.gov/agencies/dms	KI-HIPP: 855-459-6328 KCHIP: 877-524-4718
Louisiana Medicaid	Medicaid website: ldh.la.gov/healthy-louisiana Medicaid email: healthy@la.gov LaHIPP website: www.ldh.la.gov/lahipp LaHIPP email: La.HIPP@la.gov LaHIPP Mailing Address: 100 Crescent Centre Parkway, Suite 1000, Tucker, GA 30084	Medicaid: 888-342-6207 LaHIPP Phone: 877-697-6703 LaHIPP Fax: 888-716-9787
Maine Medicaid	Enrollment: www.mymaineconnection.gov/benefits/s/?language=en_US Private health insurance premium: maine.gov/dhhs/ofi/applications-forms	Enroll: 800-442-6003 Private HIP: 800-977-6740 TTY: Maine Relay: 711
Massachusetts Medicaid and CHIP	Website: www.mass.gov/masshealth/pa Email: masspremassistance@accenture.com	800-862-4840 TTY: 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	Website: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Email: HSHIPPProgram@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	Website: dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	Phone: 603-271-5218 Toll Free HIP: 800-852-3345, ext. 15218
New Jersey Medicaid and CHIP	Medicaid: https://www.nj.gov/humanservices/dmahs/individuals-families/familycare/ CHIP: njfamilycare.org/index.html	Medicaid: 800-356-1561 CHIP Premium Assist: 609-631-2392 CHIP: 800-701-0710 TTY: 711
New York Medicaid	www.health.ny.gov/health_care/medicaid	800-541-2831
North Carolina Medicaid	www.medicaid.ncdhhs.gov	919-855-4100
North Dakota Medicaid	www.hhs.nd.gov/healthcare	844-854-4825
Oklahoma Medicaid and CHIP	www.insureoklahoma.org	888-365-3742
Oregon Medicaid	www.healthcare.oregon.gov/Pages/index.aspx	800-699-9075
Pennsylvania Medicaid and CHIP	Medicaid: www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html CHIP: www.dhs.pa.gov/CHIP/Pages/CHIP.aspx	Medicaid: 800-692-7462 CHIP: 800-986-KIDS (5437)
Rhode Island Medicaid and CHIP	www.eohhs.ri.gov	855-697-4347 or 401-462-0311 (Direct RIte Share Line)
South Carolina Medicaid	www.scdhhs.gov	888-549-0820
South Dakota Medicaid	www.dss.sd.gov	888-828-0059
Texas Medicaid	www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program	800-440-0493
Utah Medicaid and CHIP	UPP Website: medicaid.utah.gov/upp/ UPP Email: upp@utah.gov Adult Expansion Website: medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: 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	Website: coverva.dmas.virginia.gov/learn/premium-assistance/famis-select HIP: Website: coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs	Medicaid/CHIP : 800-432-5924
Washington Medicaid	www.hca.wa.gov	800-562-3022

West Virginia Medicaid and CHIP	bms.wv.gov/mywvhipp.com/	Medicaid: 304- 558-1700 CHIP: 855- MyWVHIPP (855-699-8447)
Wisconsin Medicaid and CHIP	www.dhs.wisconsin.gov/badgercareplus/p-10095.htm	800-362-3002
Wyoming Medicaid	www.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, 2026, 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



Iowa Bankers Plan E HDHP PPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.wellmark.com or call 1-800-258-1415. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-258-1415 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$3,500 person/\$7,000 family per calendar year.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No. There are no other deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	\$3,500 person/\$7,000 family per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.wellmark.com or call 1-800-258-1415 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	0% coinsurance	-----None-----
	Specialist visit	0% coinsurance	0% coinsurance	Hearing exams are covered according to ACA guidelines.
	Preventive care/screening/immunization	No charge	0% coinsurance	One preventive exam per calendar year. Well-child care is covered to age 13. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	0% coinsurance	-----None-----
	Imaging (CT/PET scans, MRIs)	0% coinsurance	0% coinsurance	-----None-----
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.wellmark.com/prescriptions .	Tier 1	0% coinsurance	0% coinsurance	Refer to your Blue Rx Complete Drug List to determine the tier that applies to a covered drug. For out-of-network <u>prescription drugs</u> , you may be balance billed. You pay the <u>discounted cost</u> of your drugs until your overall deductible is met.
	Tier 2	0% coinsurance	0% coinsurance	
	Tier 3	0% coinsurance	0% coinsurance	
	Tier 4	0% coinsurance	0% coinsurance	
	Specialty drugs	0% coinsurance	Not covered	30-day supply for <u>prescription drugs</u> . 90 day prescription maximum.
		0% coinsurance	Not covered	Specialty <u>drugs</u> are covered only when obtained through the CVS Specialty Pharmacy <u>Network</u> . See wellmark.com/prescriptions for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your plan.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	0% coinsurance	-----None-----
	Physician/surgeon fees	0% coinsurance	0% coinsurance	-----None-----

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-258-1415.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	<u>Emergency room care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	For <u>emergency medical conditions</u> treated out-of-network, it is likely you may not be balance billed pursuant to the federal rules developed for implementation of the No Surprises Act.
	<u>Emergency medical transportation</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	For covered non-emergent situations, out-of-network ground ambulance services are NOT reimbursed at the in-network level. You may be balance billed for any out-of-network service as established under the rules developed for implementation of the No Surprises Act.
	<u>Urgent care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	Physician/surgeon fees	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	Outpatient services	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
If you need mental health, behavioral health, or substance abuse services	Inpatient services	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	Office visits	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Benefits shown reflect OB/GYN practitioner services which are typically globally billed at time of delivery for pre-natal, post-natal and delivery services.
If you are pregnant	Childbirth/delivery facility services	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-258-1415.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	<u>Home health care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	<u>Rehabilitation services</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	<u>Habilitation services</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	<u>Skilled nursing care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	<u>Durable medical equipment</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	<u>Hospice services</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.
If your child needs dental or eye care	Children's eye exam	0% <u>coinsurance</u>	0% <u>coinsurance</u>	One routine vision exam per calendar year, includes contact lens fittings.
	Children's glasses	Not covered	Not covered	-----None-----
	Children's dental check-up	Not covered	Not covered	-----None-----

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-258-1415.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Custodial care - in home or facility
- Dental care - Adult
- Dental check-up
- Extended home skilled nursing
- Glasses
- Hearing aids
- Long-term care
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Applied Behavior Analysis therapy
- Bariatric surgery
- Chiropractic care
- Infertility treatment (\$15,000 LTM)
- Most coverage provided outside the U.S.
- Private-duty nursing -
 - short term intermittent home skilled nursing
 - Routine eye care - Adult (one vision exam per calendar year)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, you can contact: Wellmark at 1-800-258-1415 or Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

_____ To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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This contains only a partial description of the benefits, limitations, exclusions and other provisions of the health care plan. It is not a contract or policy. It is a general overview only. It does not provide all the details of coverage, including benefits, exclusions, and policy limitations. In the event there are discrepancies between this document and the Coverage Manual, Certificate, or Policy, the terms and conditions of the Coverage Manual, Certificate, or Policy will govern.

About These Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$3,500
- PCP coinsurance 0%
- Hospital(facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$3,500
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,560

Managing Joe's type 2 Diabetes

(a years of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$3,500
- Specialist coinsurance 0%
- Hospital(facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$3,500
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$3,520

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$3,500
- Specialist coinsurance 0%
- Hospital(facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

The amounts shown in the maternity claim example above are based on amounts using a single per person deductible. Some plans may actually apply a two-person or family deductible to maternity services for the mother and newborn baby.

The plan would be responsible for the other costs of these EXAMPLE covered services.



Iowa Bankers Plan F HDHP PPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.wellmark.com or call 1-800-258-1415. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-258-1415 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$5,500 person/\$11,000 family per calendar year.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No. There are no other deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	\$5,500 person/\$11,000 family per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.wellmark.com or call 1-800-258-1415 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	Specialist visit	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Hearing exams are covered according to ACA guidelines.
	<u>Preventive care/screening/immunization</u>	No charge	0% <u>coinsurance</u>	One preventive exam per calendar year. Well-child care is covered to age 13. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	Imaging (CT/PET scans, MRIs)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.wellmark.com/prescriptions .	Tier 1	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Refer to your Blue Rx Complete Drug List to determine the tier that applies to a covered drug. For out-of-network prescription drugs, you may be balance billed. You pay the discounted cost of your drugs until your overall deductible is met. 30-day supply for <u>prescription drugs</u> . 90 day prescription maximum. <u>Specialty</u> drugs are covered only when obtained through the CVS Specialty Pharmacy <u>Network</u> . See wellmark.com/prescriptions for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your plan.
	Tier 2	0% <u>coinsurance</u>	0% <u>coinsurance</u>	
	Tier 3	0% <u>coinsurance</u>	0% <u>coinsurance</u>	
	Tier 4	0% <u>coinsurance</u>	0% <u>coinsurance</u>	
	Specialty drugs	0% <u>coinsurance</u>	Not covered	

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-258-1415.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	<u>Physician/surgeon fees</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
If you need immediate medical attention	<u>Emergency room care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	For <u>emergency medical conditions</u> treated out-of-network, it is likely you may not be balance billed pursuant to the federal rules developed for implementation of the No Surprises Act.
	<u>Emergency medical transportation</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	For covered non-emergent situations, out-of-network ground ambulance services are NOT reimbursed at the in-network level. You may be balance billed for any out-of-network service as established under the rules developed for implementation of the No Surprises Act.
	<u>Urgent care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	Facility fee (e.g., hospital room)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
If you have a hospital stay	<u>Physician/surgeon fees</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	Outpatient services	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	Inpatient services	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
If you need mental health, behavioral health, or substance abuse services	Office visits	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Benefits shown reflect OB/GYN practitioner services which are typically globally billed at time of delivery for pre-natal, post-natal and delivery services.
	Childbirth/delivery facility services	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-258-1415.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	<u>Home health care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	<u>Rehabilitation services</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	<u>Habilitation services</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	<u>Skilled nursing care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	<u>Durable medical equipment</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	<u>Hospice services</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.
If your child needs dental or eye care	Children's eye exam	0% <u>coinsurance</u>	0% <u>coinsurance</u>	One routine vision exam per calendar year, includes contact lens fittings.
	Children's glasses	Not covered	Not covered	-----None-----
	Children's dental check-up	Not covered	Not covered	-----None-----

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-258-1415.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Custodial care - in home or facility
- Dental care - Adult
- Dental check-up
- Extended home skilled nursing
- Glasses
- Hearing aids
- Long-term care
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Applied Behavior Analysis therapy
- Bariatric surgery
- Chiropractic care
- Infertility treatment (\$15,000 LTM)
- Most coverage provided outside the U.S.
- Private-duty nursing -
 - short term intermittent home skilled nursing
 - Routine eye care - Adult (one vision exam per calendar year)

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Does this plan meet the Minimum Value Standards? Yes

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Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$5,500
- PCP coinsurance 0%
- Hospital(facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
--------------------	----------

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$5,500
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$5,560

Managing Joe's type 2 Diabetes
(a years of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$5,500
- Specialist coinsurance 0%
- Hospital(facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
--------------------	---------

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$5,400
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$5,420

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible \$5,500
- Specialist coinsurance 0%
- Hospital(facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
--------------------	---------

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

The amounts shown in the maternity claim example above are based on amounts using a single per person deductible. Some plans may actually apply a two-person or family deductible to maternity services for the mother and newborn baby.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Wellmark Language Assistance

Discrimination is against the law

Wellmark complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes. Wellmark does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Wellmark

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
 - Qualified interpreters
 - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call 800-524-9242.

If you believe that Wellmark has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Wellmark Civil Rights Coordinator, 1331 Grand Avenue, Station 3E417, Des Moines, IA 50309-2901, 515-376-6500, TTY 888-781-4262, Fax 515-376-9055, Email CRC@Wellmark.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Wellmark Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意：如果您说普通话，我们可免费为您提供语言协助服务。请拨打 800-524-9242 或（听障专线：888-781-4262）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية، المجانية. اتصل بالرقم ٢٤٢٩-٤٢٥٠٠٨ أو (خدمة الهاتف النصي: ١٨٧-٨٨٨-٢٦٢٤).

ສິ່ງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານ
ໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ທີ່. (TTY: 888-781-4262.)

주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें : अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, निःशुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

ATTENTION: Si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deitsch schwetze duscht, kannscht du Hilf in dei
eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY:
888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

တၢ်ဒုးသုဉ်ညါ-နမ့ၢ်ကတိၤကညိၣ်ကိၣ်, ကိၣ်တၢ်မၤစၢၤတၢ်ဖဲးတၢ်မၤတဖၣ်, လၢတဘျီလၢၣ်ဘူးလဲ, ဆိၣ်လၢနီၢ်လီၤ. ဆဲးကျိးဆူ
၈၀၀-၅၂၄-၉၂၄ မုတမ့ၢ်(TTY: ၈၈၈-၇၈၁-၄၆၂)တက့ၢ်.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

સાવાધન: યદિ તપાઈ તપાલી બોલુહુન્દ્ર બને, તપાઈકા લાગિ નિ:શુલ્ક રૂપમા ભાષા સહાયતા સેવાહુરૂ ઉપલબ્ધ ગરાઈન્દ્ર । 800-524-9242 વા (TTY: 888-781-4262) મા સમ્પર્ક ગર્નહોસ ।

ማሳሰቢያ፡ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ አገዛ አገልግሎቶች፣ ከከፍተኛ ነፃ፣ ያገኛሉ።
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