EMPLOYEE BENEFITS GUIDE
CITY OF FORT WAYNE

— EFFECTIVE JANUARY 1, 2024 —

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Contact Information

Refer to this list when you need to contact one of our benefit vendors. For general information, contact the Benefits Department for assistance.

Medical Insurance	Provider Network - Northeast Indiana
AGA 7605 Westfield Drive, Fort Wayne, IN 46825 (260) 489-6447 / (800) 888-6472 Toll free www.aga-tpa.com	**Parkview Signature Care EPO** (800) 666-4449 www.parkview.com/signaturecaredirectory
Unlimited Doctor Access - 24/7	**Prescription Drug & Mail Order Program**
HealthiestYou (866) 703-1259 www.healthiestyou.com	**MagellanRx Management** (800) 424-0472 www.magellanrx.com
Prescription Drug Program	**LabCard Program**
RxFree4Me (866) 750-2723 RxFREE4Me.com Fax: (409) 866-5715 / faxinbox@mcc-tx.com	**LabCorp** (888) 522-2677 www.labcorp.com
Imaging Facility	**Dental Insurance**
Direct Imaging 1355 Getz Rd, Suite A, Fort Wayne, IN 46804 (260) 212-1901 www.directcarellc.net	**AGA** 7605 Westfield Drive, Fort Wayne, IN 46825 (260) 489-6447 / (800) 888-6472 Toll free www.aga-tpa.com
Voluntary Vision Insurance	**Health Savings Account (HSA)** - *for High Deductible Health Plan participants*
United Healthcare (800) 638-3120 / (800) 839-3242 Provider locator www.myuhcvision.com	866) 520-4472 HSA.UMB.com
Flexible Spending Accounts (FSA)	**Life/AD&D, Voluntary Life/AD&D, Short & Long Term Disability Insurance**
AGA 7605 Westfield Drive, Fort Wayne, IN 46825 (260) 489-6447 / (800) 888-6472 Toll free www.aga-tpa.com	**Symetra** (800) 796-3872 www.symetra.com
Voluntary Products - Hospital Indemnity, Accident, Critical Illness	**Voluntary Products - Whole Life Insurance**
UNUM (800) 421-0344 www.unum.com	Atlantic American (866) 458-7502 www.aaemployeebenefits.com
Employee Assistance Program (EAP)	**457 Plan**
Parkview (260) 266-8060 / (800) 721-8809 www.parkviewtotalhealth.com	**Lincoln Financial** www.LincolnFinancial.com Log in: Employer Retirement Plans
457 Plan	**Indiana Public Employee Retirement System**
Nationwide Patrick Burkhart (260) 385-6336 burkhp3@nationwide.com	**INPRS** (844) GO-INPRS www.inprs.in.gov
Benefit Consultant	
The DeHayes Group 11118 Coldwater Road, Fort Wayne, IN 46845 (260) 424-5600 / www.dehayes.com John Ryan, Benefit Consultant Sandy Eifert, Senior Customer Service Agent Holly Nix, Eligibility-Claims Specialist / holly@dehayes.com	

This summary provides information on the employee benefits that apply to you as an employee of the City of Fort Wayne.

Your employee benefit program offers a full range of coverage and services, and gives you the option to choose the benefits that best meet your needs. The City of Fort Wayne pays the entire cost of certain benefits, helps you pay for the cost of some benefits, while you pay the entire cost for other benefits. You contribute to the cost through payroll deductions. Overall, you create your own personal benefit program - one that makes sense for you.

This summary describes the City of Fort Wayne comprehensive benefit program, including benefits the company provides automatically and other benefits you can elect for yourself and your family.

The abbreviated outline of benefits used throughout this document are not intended to express any legal opinion as to the nature of coverage. They are only visuals to a basic understanding of coverages and do not detail all the contract terms nor do they alter any contract conditions. Benefits are subject to all terms, conditions, limitations, and exclusions outlined in the contract. Should there be any discrepancies between this summary and the actual insurance policy or plan documents, the insurance policy or plan documents will govern in all instances. Nothing contained herein should be construed as a guarantee of coverage or benefits. Please read your contract for specific coverages, limitations and exclusions.

Enrollment Considerations

Who can participate?
You are eligible to participate in the benefits described in this summary if you meet the definition of an "eligible employee or retiree" and have satisfied the waiting period.

Your eligible dependents who qualify for this coverage include:

- Your legal spouse and/or
- Your natural child, legally adopted child or child placed for adoption, stepchild, or child placed under your legal guardianship until the end of the month in which the child turns age 26. A child also includes a child for whom you are required to provide medical care or insurance under the terms of a Qualified Medical Child Support Court Order.

Please see the Summary Plan Description for details.

When Coverage Begins
Your coverage will begin on the 31st day of employment.

When Coverage Ends
Coverage will end on the last day of the month following your termination date.

Notice of Special Enrollment Rights
If you are declining enrollment for yourself and/or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

The Special Enrollment Period for the following qualifying circumstances is a period of 60 days from the event date:

- You or your dependents lose eligibility to participate in the state sponsored Medicaid or Children's Health Coverage (CHIP)
- You or your dependents qualify for a premium assistance subsidy offered by a state insurance program

To request special enrollment, you must provide the Plan Administrator with timely notice of the event and your enrollment request. See Summary Plan Description for details.

Open Enrollment
The Plan includes an annual Open Enrollment Period during which time the employee may change benefit elections or enroll himself and/or dependents in the Plan if he did not do so when first eligible or does not qualify for a Special Enrollment Period. Coverage elections made during an Open Enrollment Period are effective on the following January 1st.

NOTICE **Spousal Coordination of Benefits**

A working spouse eligible for medical expense insurance under a plan sponsored by the spouse's employer is required to take that coverage and then can be covered under the City of Fort Wayne's plan as secondary if elected. See Sumary Plan Description for details.

Your spouse's failure to enroll under the other employer plan will not constitute eligibility under this Plan.

Insurance Premiums

$1200 Deductible Plan (with Dental)

Signature Care EPO

- $30 OV Co-pay, $15/$40/$60 Rx Co-pay
- 80/20 Co-insurance, Single Max OOP - $3,700

MONTHLY RATES	
Employee Only	$69.00
Employee + Spouse Secondary*	$97.00
Employee + 1 Primary (Spouse or Child)	$128.00
Employee + Family without Spouse	$138.00
Employee + Family Spouse Secondary*	$150.00
Employee + Family Spouse Primary	$179.00

Dental Only

- $50 Deductible, $1,200 Annual Maximum
- 100% Preventive
- 90% Basic
- 60% Major Services

MONTHLY RATES	
Employee Only	$12.00
Employee + 1	$20.00
Family	$30.00

PREMIUMS ARE DEDUCTED ON A BI-WEEKLY BASIS

To calculate premium cost per paycheck: Monthly Rate x 12 (months) ÷ 26 (pay periods)

$3,400 Deductible Plan (with Dental)

Signature Care EPO

- 100% after deductible with exception of $150 ER co-pay and $40/$60 copay on name brand Rx (after deductible has been met)

MONTHLY RATES	
Employee Only	$35.00
Employee + Spouse Secondary*	$49.00
Employee + 1 Primary (Spouse or Child)	$65.00
Employee + Family without Spouse	$70.00
Employee + Family Spouse Secondary*	$76.00
Employee + Family Spouse Primary	$90.00

* "Spouse Secondary" means your spouse is covered through their employer and the City's plan will be secondary. If your spouse is not covered by another plan, the City's plan will be primary.

Voluntary Vision Plan

Employee Only	$6.76
Employee + Spouse	$13.19
Employee + Child(ren)	$13.87
Employee + Family	$21.30

Basic Life/AD&D, Short Term Disability, Long Term Disability and Employee Assistance Program (EAP) is provided at no cost you by the City of Fort Wayne (STD/LTD for non-public safety employees only)

Insurance Premiums

City of Fort Wayne

Supplemental Life Insurance Rates per Payroll Deduction (24)

EMPLOYEE	< 34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+	AD&D
$10,000	$0.35	$0.55	$0.85	$1.40	$2.50	$4.10	$5.45	$8.50	$15.00	$24.70	$0.15
$20,000	$0.70	$1.10	$1.70	$2.80	$5.00	$8.20	$10.90	$17.00	$30.00	$49.40	$0.30
$30,000	$1.05	$1.65	$2.55	$4.20	$7.50	$12.30	$16.35	$25.50	$45.00	$74.10	$0.45
$40,000	$1.40	$2.20	$3.40	$5.60	$10.00	$16.40	$21.80	$34.00	$60.00	$98.80	$0.60
$50,000	$1.75	$2.75	$4.25	$7.00	$12.50	$20.50	$27.25	$42.50	$75.00	$123.50	$0.75
$60,000	$2.10	$3.30	$5.10	$8.40	$15.00	$24.60	$32.70	$51.00	$90.00	$148.20	$0.90
$70,000	$2.45	$3.85	$5.95	$9.80	$17.50	$28.70	$38.15	$59.50	$105.00	$172.90	$1.05
$80,000	$2.80	$4.40	$6.80	$11.20	$20.00	$32.80	$43.60	$68.00	$120.00	$197.60	$1.20
$90,000	$3.15	$4.95	$7.65	$12.60	$22.50	$36.90	$49.05	$76.50	$135.00	$222.30	$1.35
$100,000	$3.50	$5.50	$8.50	$14.00	$25.00	$41.00	$54.50	$85.00	$150.00	$247.00	$1.50
$200,000	$7.00	$11.00	$17.00	$28.00	$50.00	$82.00	$109.00	$170.00	$300.00	$494.00	$3.00
$300,000	$10.50	$16.50	$25.50	$42.00	$75.00	$123.00	$163.50	$255.00	$450.00	$741.00	$4.50
$400,000	$14.00	$22.00	$34.00	$56.00	$100.00	$164.00	$218.00	$340.00	$600.00	$988.00	$6.00
$500,000	$17.50	$27.50	$42.50	$70.00	$125.00	$205.00	$272.50	$425.00	$750.00	$1,235.00	$7.50
*SPOUSE	< 34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+	AD&D
$5,000	$0.18	$0.28	$0.43	$0.70	$1.25	$2.05	$2.73	$4.25	$7.50	$12.35	$0.08
$10,000	$0.35	$0.55	$0.85	$1.40	$2.50	$4.10	$5.45	$8.50	$15.00	$24.70	$0.15
$15,000	$0.53	$0.83	$1.28	$2.10	$3.75	$6.15	$8.18	$12.75	$22.50	$37.05	$0.23
$20,000	$0.70	$1.10	$1.70	$2.80	$5.00	$8.20	$10.90	$17.00	$30.00	$49.40	$0.30
$25,000	$0.88	$1.38	$2.13	$3.50	$6.25	$10.25	$13.63	$21.25	$37.50	$61.75	$0.38
$30,000	$1.05	$1.65	$2.55	$4.20	$7.50	$12.30	$16.35	$25.50	$45.00	$74.10	$0.45
$35,000	$1.23	$1.93	$2.98	$4.90	$8.75	$14.35	$19.08	$29.75	$52.50	$86.45	$0.53
$40,000	$1.40	$2.20	$3.40	$5.60	$10.00	$16.40	$21.80	$34.00	$60.00	$98.80	$0.60
$45,000	$1.58	$2.48	$3.83	$6.30	$11.25	$18.45	$24.53	$38.25	$67.50	$111.15	$0.68
$50,000	$1.75	$2.75	$4.25	$7.00	$12.50	$20.50	$27.25	$42.50	$75.00	$123.50	$0.75
$100,000	$3.50	$5.50	$8.50	$14.00	$25.00	$41.00	$54.50	$85.00	$150.00	$247.00	$1.50

	CH Life	CH AD&D	CH Life	CH AD&D	CH Life	CH AD&D	CH Life	CH AD&D	CH Life	CH AD&D
CHILD(REN)	$2,000	$2,000	$4,000	$4,000	$6,000	$6,000	$8,000	$8,000	$10,000	$10,000
	$0.07	$0.03	$0.14	$0.06	$0.21	$0.09	$0.28	$0.12	$0.35	$0.15

*Spouse's rate is based on spouse's age.

Symetra® is a registered service mark of Symetra Life Insurance Company. www.symetra.com

Medical - $1,200 Deductible EPO Plan - Grandfathered

Administered by:

As an employee the health insurance benefits available to you represent a significant component of your compensation package and they provide important protection to keep you and your family in good health. The City of Fort Wayne offers eligible employees and their dependents a comprehensive PPO (Preferred Provider Organization) health insurance plan administered by Automated Group Administration (AGA). To receive the highest level of benefits, you must utilize the Provider Network.

	Traditional Plan - $1,200 Deductible		
BENEFITS	**EPO Hospital & PPO Providers**	**PPO Hospital & No EPO Hospital or PPO Provider Available**	**Non-PPO Hospitals & Providers**
Deductible, per calendar year *(Embedded)*	$1,200 Individual / $3,600 Family	PPO Hospital - $2,200 Individual / $6,600 Family No EPO Hospital or PPO Available - $1,200 Individual / $3,600 Family	$4,200 Individual / $12,600 Family
Co-Insurance Benefit	80%	70%	50%
Maximum Out-of-Pocket, per calendar year *(does not include deductible & Rx copays)*	$2,500 Individual / $5,000 Family	PPO Hospital - $5,500 Individual / $11,000 Family No EPO Hospital or PPO Available - $2,500 Individual / $5,000 Family	$14,000 Individual / $28,000 Family
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Covered Services			
Inpatient Hospital	80% after deductible	70% after deductible	50% after deductible
Outpatient Surgery	80% after deductible	70% after deductible	50% after deductible
Emergency Room	80% after deductible	70% after deductible	50% after deductible
Maternity Services	80% after deductible	70% after deductible	50% after deductible
Physician Office Visit (Visit only) All other services subject to deductible and coinsurance	$30 Copay	$30 Copay	50% after deductible
Preventive Care Physical exam, well-baby, immunizations, PSA's, etc.	$30 Copay up to $2,000 benefit, then deductible, then 20%	$30 Copay up to $1,000 benefit, then deductible, then 30%	50% after deductible
Urgent Care Visit (Visit Only) All other services subject to deductible and coinsurance	$35 Copay	$35 Copay	$35 Copay
Ambulance Services	80% after deductible	80% after deductible	80% after deductible
Chiropractic Services - Spinal Limited to 25 visit per calendar year	80% after deductible	80% after deductible	80% after deductible
Physical, Occupational & Speech Therapy	80% after deductible	70% after deductible	50% after deductible
Mental Health, Alcohol & Substance Abuse	80% after deductible	70% after deductible	50% after deductible
Laboratory Services If Lab Card used: 100%, not subject to deductible	80% after deductible	70% after deductible	50% after deductible
Retail and Mail Order Prescription Drugs			
Prescription Drug **Retail 34 Day Supply** ***(Walgreens is excluded)***	Generic - $15 copay Formulary Brand no generic available - $40 copay Non-Formulary Brand no generic available - $60 copay Brand generic is available - $15 copay plus difference	N/A	Not Covered
Prescription Drugs Mail Order 90 Day Supply	Generic - $30 copay Formulary Brand - $80 copay Non-Formulary Brand - $120 copay	N/A	Not Covered

- The out of pocket limit does NOT include premiums, deductibles, copays, balance-billed charges, pre-cert penalties and excluded charges
- Benefits apply to network retail pharmacies, no coverage at Walgreens
- Balance billing protection when you use an in-network provider
- In-patient hospital admission and many out-patient procedures require mandatory notification to Managed Care Concepts: 1-866-750-2723

Medical - $3,400 Deductible HSA EPO Plan - Grandfathered

Administered by:

As an employee the health insurance benefits available to you represent a significant component of your compensation package and they provide important protection to keep you and your family in good health. The City of Fort Wayne offers eligible employees and their dependents a comprehensive PPO (Preferred Provider Organization) health insurance plan administered by Automated Group Administration (AGA). To receive the highest level of benefits, you must utilize the Provider Network.

	High Deductible Health Plan - $3,400 Deductible		
BENEFITS	EPO Hospital, PPO Providers, No EPO Hospital or PPO Provider Available	PPO Hospital	Non-PPO Hospitals & Providers
Deductible, per calendar year *(Embedded)*	$3,400 Individual / $6,800 Family	$4,400 Individual / $8,800 Family	$7,000 Individual / $14,000 Family
Co-Insurance Benefit	100%	90%	50%
Maximum Out-of-Pocket, per calendar year *(does not include deductible & Rx copays)*	$0 Individual / $0 Family	$3,000 Individual / $6,000 Family	$14,000 Individual / $28,000 Family
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Covered Services			
Inpatient Hospital	100% after deductible	90% after deductible	50% after deductible
Outpatient Surgery	100% after deductible	90% after deductible	50% after deductible
Emergency Room	$150 copay then 100% after deductible	$150 copay then 90% after deductible	$150 copay then 50% after deductible
Maternity Services	100% after deductible	90% after deductible	50% after deductible
Physician Office Visit	100% after deductible	N/A	50% after deductible
Preventive Care Physical exam, well-baby, immunizations, PSA's, etc.	100% up to $2,000, then 100% after deductible	N/A	50% after deductible
Urgent Care Visit (Visit Only) All other services subject to deductible and coinsurance	100% after deductible	N/A	50% after deductible
Ambulance Services	100% after deductible	N/A	100% after deductible
Chiropractic Services - Spinal Limited to 25 visit per calendar year	100% after deductible	100% after deductible	100% after deductible
Physical, Occupational & Speech Therapy	100% after deductible	90% after deductible	50% after deductible
Mental Health, Alcohol & Substance Abuse	100% after deductible	90% after deductible	50% after deductible
Laboratory Services If Lab Card used: DISCOUNT AVAILABLE	100% after deductible	90% after deductible	50% after deductible
Retail and Mail Order Prescription Drugs			
Prescription Drug **Retail 34 Day Supply** ***(Walgreens is excluded)***	Generic - 100% after deductible Formulary Brand no generic available - $40 copay after deductible Non-Formulary Brand no generic available - $60 copay after deductible Brand Generic is available - $15 plus difference after deductible	N/A	Not Covered
Prescription Drugs Mail Order 90 Day Supply	Generic - 100% after deductible Formulary Brand - $80 copay after deductible Non-Formulary Brand - $120 copay after deductible	N/A	Not Covered

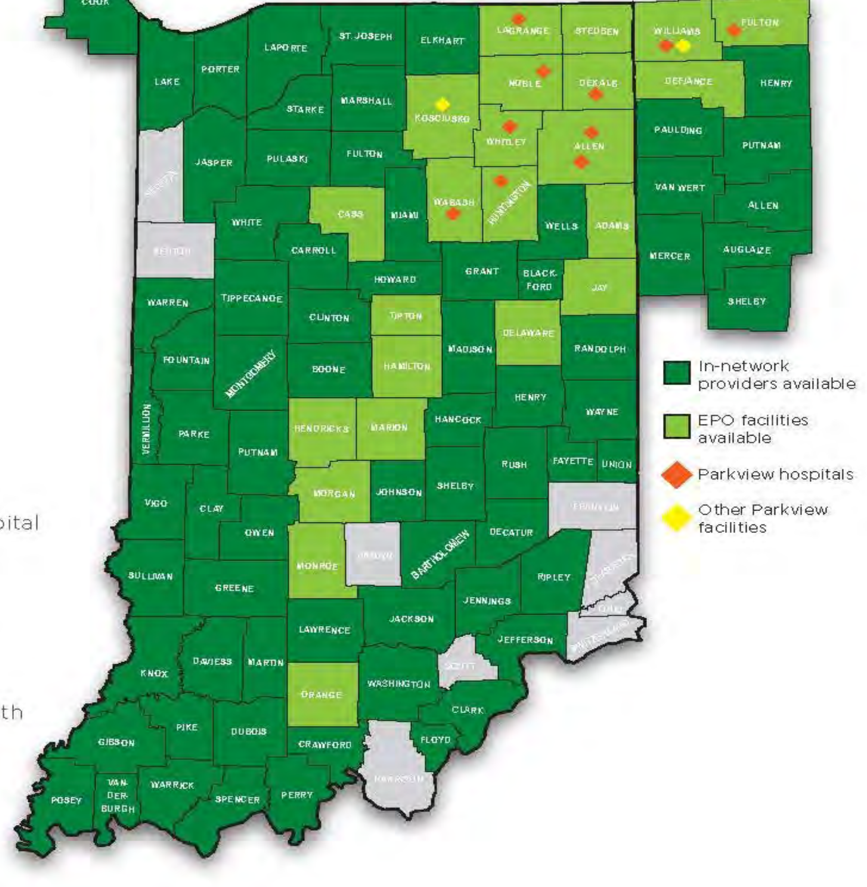
- The out of pocket limit does NOT include premiums, deductibles, copays, balance-billed charges, pre-cert penalties and excluded charges
- Benefits apply to network retail pharmacies, no coverage at Walgreens
- Balance billing protection when you use an in-network provider
- In-patient hospital admission and many out-patient procedures require mandatory notification to Managed Care Concepts: 1-866-750-2723

Provider Networks

SIGNATURE CARE EPO NETWORK

The Signature Care EPO (Exclusive Provider Organization) network is dedicated to providing members with the best healthcare providers at the best rate. Members receive the highest level of benefit coverage when utilizing one of these EPO facilities.

Signature Care EPO facilities and in-network providers are located in the counties indicated on this map.



Allen County Facilities

Parkview Hospital Randallia
Parkview Regional Medical Center
Parkview Behavioral Health
Parkview Ortho Hospital
Parkview Premier Surgery
Parkview Southwest
Parkview Endoscopy Center
Parkview SurgeryONE

Other Indiana Facilities

Parkview DeKalb Hospital
Parkview Huntington Hospital
Parkview LaGrange Hospital
Parkview Noble Hospital
Parkview Wabash Hospital
Parkview Warsaw
Parkview Whitley Hospital
Adams Memorial Hospital
Cameron Memorial Community Hospital
Logansport Memorial Hospital

IU Health System

IU Health Methodist Hospital
IU Health Ball Memorial Hospital
IU Health University Hospital
IU Health Bloomington Hospital
Riley Hospital for Children at IU Health
IU Health Jay

Ohio Facilities

Parkview Bryan Hospital
Parkview Montpelier Hospital
Parkview Archbold
Community Memorial Hospital (Defiance County)

To view all Signature Care providers throughout Indiana and northwest Ohio, visit our online directory at Parkview.com/SignatureCareDirectory

MKTG-32537 (10/23)

Provider Networks

Quick Reference Guide to In-Network Care

Parkview Physicians Group (PPG) Access Center

1-877-PPG-TODAY (774-8632) I ppg.parkview.com

Looking for a doctor? At Parkview Physicians Group, you get more than a doctor. You get an entire care team working together to keep you well. Primary care doctors, nurse practitioners, physician assistants, nurses, even nutritionists are available to coach you to better health.

- Appointment scheduling for new and existing patients.
- 24/7 nurse navigation to appropriate care.
- Connection to nearly 50 different specialties.

Parkview Welcome Clinic

844-901-1577

Looking to establish a relationship with a primary care provider or specialist? The Parkview Welcome Clinic can get you started on your journey to better health.

- Easy access to an initial wellness/preventive visit.
- Comprehensive medical evaluation.
- Complete prevention screenings.
- Coordination of a personalized care plan and a referral to a Parkview primary care provider or specialist.
- Resources to help you understand your healthcare benefits, related to your healthcare needs.

Signature Care Provider Directory

260-266-5510 or 800-666-4449
parkview.com/employersolutions

Visit us online or contact customer service to find in-network providers and facilities.

Parkview MyChart

mychart.parkview.com

MyChart is a secure and confidential web-based system that allows you to communicate with your physician's office and access many of your healthcare records any time, day or night. MyChart enables you to:

- View your health summary, including current medications, allergies and immunizations.
- Request and cancel appointments.
- Send and receive secure messages with your provider.
- Virtual walk-in clinic option to talk to a Parkview provider and receive the same level of care as an in-person visit at a walk-in clinic.
- MyChart video visits allows you to schedule a virtual appointment with your Parkview provider.
- Request prescription refills.
- View and print lab results.

PARKVIEW MyChart

Parkview FirstCare Walk-in Clinics

parkview.com/firstcare

When you need medical care in a hurry, Parkview FirstCare Walk-in Clinics are here for all your minor illnesses and injuries. They're open at convenient hours, and you never need an appointment or a doctor's referral. There are no inflated costs for urgent care. Our walk-in visits are billed at the same rate as a normal office visit.

- 13 convenient locations in northeast Indiana and northwest Ohio.
- Virtual Walk-in Clinic available. Visit Parkview.com to learn more.

Parkview OnDemand

parkview.com/ondemand

Board certified doctors are available by phone or video 24/7 to diagnose, treat and write prescriptions for things like:

- Cold and flu symptoms
- Allergies
- Respiratory infections
- Ear infections
- Pink eye
- Skin rashes
- And more

It's quality, convenient care for non-emergencies - all for just $49 a call.

Prescription Drugs

The Magellan Rx Mobile App

On-hand prescription drug management tools for members

Our mobile app is designed to help members understand and maximize their prescription drug benefits through key tools that elevate the pharmacy experience. Members will have access to real-time prescription updates, critical clinical information and cost management tools all in the palm of their hand.

Members can:

1. **Check the status of their prescriptions**
   - Transparency is key and the Magellan Rx app makes it easy to see where a prescription is in the review process with 6 easy statuses:

Ready

Not ready

Under review

Needs approval

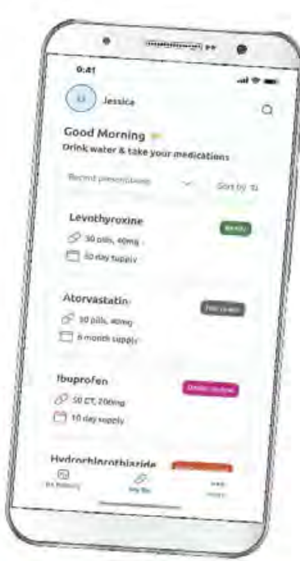
Quantity limit

Not covered

   - Members can opt-in to receive prior authorization notifications for new submissions, status updates and expirations.

2. **Price a drug**
   Members can get accurate drug pricing from nearby pharmacies so they can make the best decision on where to fill a prescription.
3. **Get detailed clinical content for their prescription**
   Including alerts for severe drug interactions and adverse reactions, as well as general information about the medication.
4. **Receive notifications**
   Members will receive notifications for prescription refills, severe drug-drug interactions, and prior authorization status updates.*
5. **View Rx claims history**
   Members can view a comprehensive history of previously filled prescriptions.

*Available November 1



Coming in 2022!

Live chat with a customer service agent

Schedule home delivery for prescriptions

The Magellan Rx app is available on the Apple app store and Google play store.

Want to learn more? Connect with us!

magellanrx.com mrxinquiries@magellanhealth.com
Magellan Rx Management Magellan Rx Magellan Rx

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Prescription Drugs

Access your prescription history, schedule a refill and more!

At Magellan Rx Management, we are on a quest to provide a connected healthcare experience that truly leads humanity to healthy, vibrant lives. We are committed to delivering quality service and personalized care. Our secure member portal makes it easy for you to quickly refill your prescription and check your order status while also providing access to additional support to help you stay on track.

STEP ONE

Visit www.magellanrx.com and select Portal Access: Member.

STEP TWO

Login. If it's your first time on the site, you will need to complete the one-time registration process.

To register, fill out the registration form. Click on confirmation link sent to the email you registered with within 24 hours (if you don't click on the link within 24 hours you will need to re-register).

The link will take you to the member login page and will complete your registration.

STEP THREE

Get to know your dashboard. It's easy to view recent claims, renew and refill prescriptions, access on-demand medication videos and more!

magellanrx.com

Prescription Drugs

IF YOU SELECT MAIL ORDER UNDER TOOLS & RESOURCES:

If you take maintenance medications for long-term conditions like arthritis, asthma, diabetes, high blood pressure or high cholesterol, home delivery through Magellan Rx Pharmacy may be a helpful solution for you.

1. Click on Tools & Resources in the navigation bar to make your selection. Select Mail Order to fill your maintenance medication prescription.

2. Select the "Refill?" checkbox for each prescription you would like to refill and click continue.

3. Enter your preferred shipping address and click continue.

4. Enter your billing information and click continue.

5. Review your order details and click submit.

Success! Your order has been submitted.
Please make a note of your confirmation number.

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Prescription Drugs

IF YOU SELECT SPECIALTY PHARMACY UNDER TOOLS & RESOURCES:

You will need to register under the Specialty Pharmacy section if you receive a specialty medication through Magellan Rx Pharmacy. This will help you get the medications you need and the personalized support and care needed to successfully manage your condition.

1. Click on Tools & Resources in the navigation bar to make your selection. Select Specialty Pharmacy to fill your specialty medication prescription.

2. If you are a first time user, enter your Member Record Number (MRN) and click submit.
To obtain your MRN, please call 866.554.2673.

3. There is a manual activation period of 24 hours. You will receive an email once your activation is complete.

4. Once the activation is complete, visit www.magellanrx.com and follow steps 1-3 to access your secure member information.

magellanrx.com

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Prescription Drugs

ADDITIONAL RESOURCES:

Smart Pharmacy Locator

- Locate pharmacies in your area
- Set default pharmacy

Medication Videos

In an effort to empower our members with rich, relevant content for more informed healthcare decision-making, we offer more than 500 medication videos through our member portal. These videos provide:

- Traditional and specialty medication details
- Disease education
- Side effect awareness

Price a Drug

- Auto-complete feature assists in searching for a drug
- Ability to select from previously filled drug and see dosage and strength options based on the drug selected
- Comparative drug pricing for up to three retail pharmacies
- Drug pricing messages in clear, understandable language

Login today at magellanrx.com.

If you have any questions about your prescription benefits, please call us at 1.800.424.0472.

magellanrx.com

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Prescription Drugs

medtipster™/free

Helping You Save Money on Generic Medications

Clinically-based solutions for improved adherence

At Magellan Rx Management, we are dedicated to helping people live healthy, vibrant lives. Magellan Rx has partnered with medtipster™/free to help you find savings on generic medications at local pharmacies. You can use your prescription ID card and medtipster/free's convenient website to find thousands of generic prescription medications available at no cost to you.

How to Use medtipster/free Program

1. Visit medtipster/free.com
2. Search for drug name: Enter drug name, dosage and zip code
3. Locate Pharmacy
4. Pick up Prescription: Present your medtipster ID card and pick up your generic medications for $0

Questions?

Please call 800.424.0472 or send an email to contact@medtipster.com.

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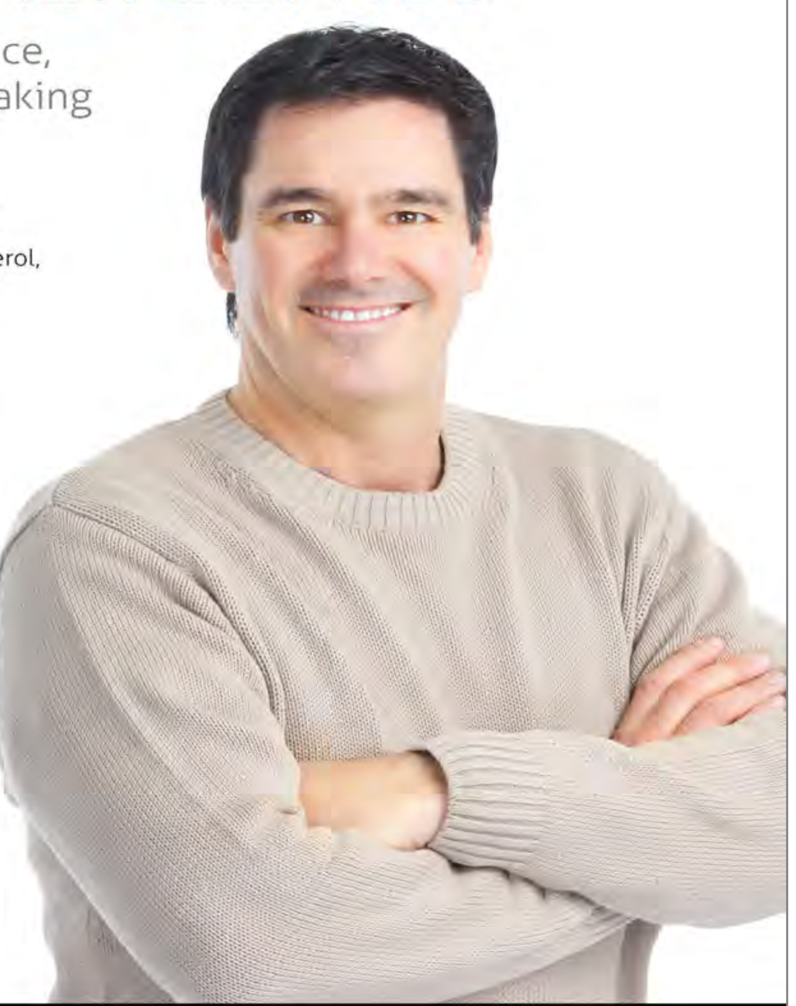
Prescription Drugs

Moving Beyond Traditional Mail-Service

Offering Savings, Convenience, and Education for Patients taking Maintenance Medications

For patients taking maintenance medications for long-term conditions like arthritis, asthma, diabetes, high blood pressure or high cholesterol, we provide the convenience and cost saving option of Magellan Rx Home, Magellan Rx Management's mail service pharmacy.



Benefits of Magellan Rx Home

- ✓ Free shipping on all standard orders
- ✓ Auto Refill Program for routine maintenance therapies
- ✓ RefillPro application for easy reorder from a smartphone or mobile device
- ✓ Investigation of Financial assistance programs
- ✓ Dedicated pharmacists and nursing support with 24/7/365 access
- ✓ Easy to use web portal enables patients to view profile, schedule refills, check order status and review payment information

magellanrx.com

Magellan Rx MANAGEMENT

Prescription Drugs

Mail-Service Offerings

At Magellan Rx, our mail-service pharmacy goes beyond filling a prescription. We believe the best way to empower our patients to take control of their health is to make it affordable and easy to understand. We offer:

Cost Savings

Depending on your plan design, patients can get up to a 90-day supply of their medication for less money than three separate fills and standard shipping is free.

Convenience

Refill medication just once every three months easily online or by phone. That means no more drive time or waiting at the pharmacy.

Education

On-demand access to informative medication videos through easy-to-scan codes, right at their fingertips.

Support

Medication is mailed quickly and securely. Registered pharmacists check all orders and are available for help 24/7.

Scan your Rx label with your mobile device

Available right on your prescription to scan anytime you want more information on your medication

Watch customized videos about your Rx

Learn More about Magellan Rx Management Today

At Magellan Rx, we provide unparalleled depth of knowledge, proven cost-savings options, and a partnership culture that uniquely adapts to the needs of our clients. It's an innovative pharmacy benefit approach that leads to more efficient cost control, personalized member and client service, improved outcomes and increased satisfaction.

Contact us today at **800.659.4112** or visit **magellanrx.com** to learn more.

magellanrx.com

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Magellan Rx MANAGEMENT

Prescription Drugs

As your pharmacy benefit manager, Magellan Rx Management wants to help you and your family make good choices about your health.

As part of the MRx Select Savings program, we've teamed with *Paydhealth* to bring you their **Select Drugs and Products℠** program. This program helps lower your healthcare costs by seeking sources of alternate funding for select specialty drugs.

Here are a few things you need to know:

Enrollment in the program provides an opportunity to substantially reduce your specialty drug out-of-pocket cost—in many cases to no cost at all.

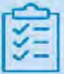
You must enroll in the program to receive these benefits. Otherwise, your specialty medications will not be covered. This means you would have to pay the full cost of the specialty drug.

All specialty drugs on the Select Drugs and Products list require review.

Your case must be submitted to alternate funding before your benefits will apply.

If you are taking a specialty drug:

A Paydhealth program case coordinator will contact you.



Your case coordinator will tell you what you need to know about the program and will walk you through the enrollment process and requirements.

If you have any questions regarding this program, please call Paydhealth's Specialty Contact Center at 877.869.7772 (8:00 a.m. – 8:00 p.m. CST).

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Prescription Drugs

RxFREE4me

100% FREE TO YOU NO CO-PAY

GETTING STARTED IS AS EASY AS

1 2 3

Your employer has partnered with RxFREE4Me to make several medications 100% FREE.

All insulin, most brand drugs, and many more are available to you. RxFREE4Me offers 24/7 customer support with over 1.2 million members served.
Start saving today and enroll in less than 5 minutes.

2 Answer a few brief questions

3 Receive your Rx FREE

CONTACT US TO START SAVING TODAY!

Nationwide Pharmacy | 24/7 Member Support | RxFree4Me.com
faxinbox@mcc-tx.com | (866) 750-2723 | Fax: (409) 866-5715

Save Money on Prescription Drugs

Reduce Your Prescription Drug Costs

Five questions you should ask your doctor if a medication is prescribed:

- Before I start the medication are there any changes to my life-style I can make to improve my condition?
- Is there a generic medication that can be prescribed for this condition? If not, is there a lower-priced brand name medication available?
- Do you have free samples of the prescribed medication available?
- Is there an effective pill-splitting dosage for the prescribed medication?
- Can you write one 30 day medication and one 90 day so I can save by using the mail order pharmacy?

Generic Prescription Drugs Can Save You Money

Generic drugs are a lower cost alternative to name brand medications. If your prescription is for a name brand medication, ask your doctor to recommend a generic alternative so that you can save money.

Refer to the following websites for a listing of generic medications at a store nearest you. Some pharmacies require enrollment in a program to receive the discount. A small membership fee may be required. Check with each pharmacy for details and costs.

Wal-mart	www.walmart.com/pharmacy	$4 for 30 day supply / $10 for 90 day supply
CVS	www.cvs.com/extracare-cvs/rxrewards	ExtraCare Pharmacy & Health Rewards Program
Target	www.target.com/pharmacy *(operated by CVS)*	ExtraCare Pharmacy & Health Rewards Program
Kroger	www.krogersc.com/pharmacy	Rx Savings Club (membership fee required)
Meijer	www.meijer.com/pharmacy	Free Antibiotics, Select Prenatal Vitamins, Metformin & Atorvastatin Calcium

Search Engines

Prices for prescription drugs vary widely between pharmacies, even those across the street from each other. The search engines are free to consumers and easy to use. They allow consumers to compare prices and discounts through pharmacies nearest you, drug manufacturers and other sources for the best price on that drug.

Medtipster	www.medtipster.com
GoodRx	www.goodrx.com

Value Added Programs

Your healthcare just got a whole lot easier!

With HealthiestYou you can connect with a doctor who can diagnose, treat, and prescribe over the phone 24/7/365. Using HealthiestYou can SAVE YOU TONS OF MONEY and no more time wasted in waiting rooms or trying to schedule an appointment.

Our doctors are licensed and can handle an array of common ailments including allergies, earache, sore throat, pink eye, strep throat, urinary tract infection, and many more! HealthiestYou is great for families because your spouse and dependants can use it too. There is no limit on the number of times called or the duration of each call. And the best part... **it's FREE!**

Talk to a doctor

Talk to a licensed, board-certified doctor to get a diagnosis and a treatment plan.

Get a prescription

If medically necessary, a prescription may be provided and electronically sent to a pharmacy of your choice.

Feel Better Soon

We hope you feel better quickly, but if not, call and talk to the doctor again. There is no limit to visits.

DOWNLOAD THE APP!

No Smartphone or Internet? No Problem! Simply call

866.703.1259

- 24x7 Unlimited doctor access
- FREE to use
- Access by app or telephone
- Spouse and dependant use
- Find a nearby doctor, pharmacy, urgent care, ER, or even a vet
- Price and save on prescriptions
- Price procedures
- Search and compare doctors
- Friendly reminders to save

Value Added Programs

TOP 50 HY DIAGNOSES

1. ACUTE UPPER RESPIRATORY INFECTIONS OF UNSPECIFIED SITE
2. ACUTE SINUSITIS UNSPECIFIED
3. ACUTE PHARYNGITIS
4. URINARY TRACT INFECTION
5. ACUTE BRONCHITIS
6. ACUTE CONJUNCTIVITIS UNSPECIFIED
7. UNSPECIFIED OTITIS MEDIA
8. STREPTOCOCCAL SORE THROAT
9. ALLERGIC RHINITIS CAUSE UNSPECIFIED
10. COUGH
11. INFECTIVE OTITIS EXTERNA UNSPECIFIED
12. ACUTE NASOPHARYNGITIS (COMMON COLD)
13. OTALGIA UNSPECIFIED
14. OTHER ACUTE PAIN
15. CONTACT DERMATITIS, NOS
16. RASH AND OTHER NONSPECIFIC SKIN ERUPTION
17. VAGINITIS AND VULVOVAGINITIS UNSPECIFIED
18. CANDIDIASIS OF VULVA AND VAGINA
19. ABDOMINAL PAIN UNSPECIFIED SITE
20. CELLULITIS AND ABSCESS OF UNSPECIFIED SITES
21. ACUTE CYSTITIS
22. HERPES SIMPLEX WITHOUT COMPLICATION
23. FEVER UNSPECIFIED
24. ACUTE TONSILLITIS
25. PAIN, LOW BACK
26. UNSPECIFIED DENTAL CARIES
27. UNSPECIFIED VIRAL INFECTION
28. INFECTIOUS COLITIS ENTERITIS AND GASTROENTERITIS
29. CONJUNCTIVITIS, VIRAL NOS
30. INFLUENZA WITH OTHER RESPIRATORY MANIFESTATIONS
31. OTHER ACUTE OTITIS EXTERNA
32. ACUTE GOUTY ARTHROPATHY
33. EXERCISE-INDUCED BRONCHOSPASM
34. UNSPECIFIED CONSTIPATION
35. NAUSEA WITH VOMITING
36. CROUP
37. UNSPECIFIED ESSENTIAL HYPERTENSION
38. DEHYDRATION
39. CONJUNCTIVITIS, MUCOPURULENT
40. ALLERGIC URTICARIA
41. TOBACCO USE DISORDER
42. DIARRHEA OF PRESUMED INFECTIOUS ORIGIN
43. INSECT BITE NONVENOMOUS OF TRUNK WITHOUT INFECTION
44. CONTACT DERMATITIS AND OTHER ECZEMA DUE TO OTHER SPECIFIED AGENTS
45. SCABIES
46. ACUTE SWIMMERS' EAR
47. DIARRHEA, NOS
48. MYALGIA AND MYOSITIS UNSPECIFIED
49. HERPES ZOSTER WITHOUT COMPLICATION
50. EXTERNAL HEMORRHOIDS WITHOUT COMPLICATION

Value Added Programs

LabCorp
LabDirect[SM]

Designed to Save You Money on Lab Testing Services

What if my doctor doesn't collect specimens in his/her office?
If your doctor does not collect specimens in his/her office, visit LabCorp's Web site at www.labcorp.com or call 888-522-2677 (888-LabCorp) to locate a specimen collection lab near you.

LabCorp offers more than 1700 convenient patient service centers across the nation.

For a Patient Service Center Near You:
888-LabCorp (888-522-2677)
www.labcorp.com

What if I receive a bill for my laboratory testing?
If you receive a bill for your laboratory services after receiving a denial notice on your explanation of benefits (EOB), please contact your employer for assistance. If the service is denied as a non-covered service, you will be responsible for payment. If you have specific questions about what is covered, please consult the provider of your medical plan.

Quality Patient Care and Convenient Access

What is LabCorp LabDirect?
LabDirect is a program offered by your employer that helps you and your covered dependents save money on covered laboratory services when testing is performed at LabCorp. Your employer saves money too, because lab testing services are provided at a discounted price.

The LabCorp LabDirect program has a two-tiered benefit design. Your employer/insurance company will assign your benefit level depending on your plan design.

What is the Platinum benefit?
When covered laboratory services are performed by LabCorp, Platinum covered employees and their dependents will have no out-of-pocket costs and will not receive a bill from LabCorp.

What is the Gold benefit?
When covered services are performed by LabCorp, Gold covered employees and their dependents can save money on laboratory services. Please contact your employee benefits manager for more information.

Who is LabCorp?
LabCorp is one of the nation's largest clinical laboratories. We perform tests and provide timely, accurate results that help your doctor screen for, diagnose, and manage your health. We operate more than 1700 locations nationwide to provide you with convenient access to high-quality laboratory testing services.

How do I take advantage of the LabDirect program?
Simply present a physician's order for covered laboratory testing and your insurance card with the LabCorp logo at any LabCorp specimen collection lab.

Where can I go to receive discounted testing services?
LabDirect is accepted at more than 1700 LabCorp specimen collection labs throughout the nation. To locate a specimen collection lab near you, use the Find a Lab feature on LabCorp's Web site at www.labcorp.com or call 888-522-2677 (888-LabCorp). LabCorp also allows you to schedule, modify, or cancel appointments online. This is a convenient, flexible way to minimize your wait time at the specimen collection lab.

LabCorp's specimen collection labs are staffed by qualified, caring employees dedicated to complete customer satisfaction.

What services are covered by the LabDirect program?
Most routine outpatient laboratory tests, such as common blood and urine testing, cultures, Pap tests, and tissue biopsies are covered. A complete list of covered services can be found in the health care plan provided to you by your employer.

What services are not included?
The LabDirect program does not include:

- Testing performed by another laboratory.
- Testing performed while you are in the hospital.
- STAT (emergency need) testing.
- Time-sensitive, esoteric testing (for example, fertility testing, bone marrow studies, spinal fluid tests, etc).
- Testing that is not approved and/or covered by your current benefit plan.

Do I have to use the LabDirect program?
You are not required to use the LabDirect program. However, by participating in the program, Platinum members and their covered dependents will have no out-of-pocket costs for covered laboratory testing services. Gold members and their covered dependents can save money on covered laboratory services.

What if my doctor doesn't know anything about the LabDirect program?
When you visit your doctor, show your insurance card with the LabCorp logo to the office staff, and tell them that any laboratory testing should be performed by LabCorp. Ask the office staff to call 800-377-9364 to schedule a specimen pickup, and a Client Services representative will be happy to explain the purpose of the LabDirect program. You may also ask your doctor's office staff to contact LabCorp before your next visit to get any needed information before your appointment.

What if my doctor wants to perform the testing in his/her office or have it performed in a lab other than LabCorp?
You may choose to have your testing performed by another lab; however, you will be responsible for your standard copays, coinsurance, and deductibles and will not receive the LabDirect discount.

labcorp

Designed to save you money on Lab Testing Services

To locate a LabCorp specimen collection Lab, visit LabCorp's website at www.labcorp.com or call (888) 522-2677

Value Added Programs

Imaging Discount Services (MRI, CT, Ultrasound, X-Ray)

Direct Imaging LLC, a subsidiary of DirectCare LLC, is a freestanding outpatient imaging services (MRI, CT, Ultrasound and X-rays) facility, located at 1355 Getz Rd, Suite A, Fort Wayne, IN 46804, that offers the most affordable out-of-pocket cost in the area. You are not required to use the discount program; however, by participating in the program, you and your covered dependents can save money on covered imaging services.

Professional interpretation

- All exams are interpreted by Summit Radiology board-certified radiologists
- Images and reports are available through their secure, HIPPA-compliant website or via CD

Fast and Efficient

Results are sent within 24 hours, but can be sent STAT upon request.

One Flat Rate

The low pricing includes the cost of your exam and the radiologists interpretation. No hidden costs or fees.

Lower Out-of-pocket Cost

The Direct Imaging program helps you and your covered dependents save money on covered imaging services when testing is performed at Direct Imaging in Fort Wayne. This program allows you to receive substantial discounts on imaging services, and in some cases may be free.

Advanced Technology

MOST ADVANCED INDEPENDENT FREE-STANDING IMAGING FACILITY IN FORT WAYNE

High quality 1.5 Tesla MRI, 64 Slice CT, Digital X-Ray, and Ultrasound

Same or Next-day Appointments

Being a "Patient" isn't about waiting. They will find a time that works for you.

Rapid Results

The technology ecosystem allows for a quick report turn-around time, in most instances within 24 hours. Providers can secure access to view images anywhere and have the ability to burn onto a CD.

Comfort and Convenience

Getting an MRI might feel like a big step. They will do their best to make it a comfortable and relaxing experience.

1355 Getz Rd, Suite A, Fort Wayne, IN 46804

P: 260.212.1901 F: 260.999.5889

Value Added Programs

Managed Care Concepts: Healthy Track

Successfully managing your life with diabetes can be challenging. Healthy Track is a platform of healthcare services designed to get and keep you on a "healthy track". This is accomplished through the FDA approved MyGHR system which provides real time data and comprehensive Nurse Navigator support.

WHAT IS INCLUDED?

Healthy Track includes a Genesis Blood Glucose Monitor and MyGHR system, as well as 24-hour access to the Diabetic Care Line (1-866-751-2723) and full access to the Health Track Nurse Support line (1-866-750-2723).

The Genesis Blood Glucose Meter accurately tests glucose levels and automatically sends the results to the patient's secure and personal on-line MyGHR account, which can be shared with healthcare professionals or individuals involved in patient care. The Genesis meter has an intuitive user interface and is easy to use, including a color LCD screen, rechargeable battery and the ability to store up to 450 readings.

WHY USE HEALTHY TRACKS?

The MyGHR system eliminates the need for traditional paper logbooks and contains features for running test history reports. In addition, the system can be programmed to send text message alerts of test results to any mobile phone or to your physician!

HOW DO I PARTICIPATE?

Call the Diabetic Nurse Line Support at 1-866-751-2723 to begin!

Value Added Programs

Daavlin Home Phototherapy Benefit

Phototherapy is a safe and highly effective treatment for such skin diseases as psoriasis, eczema, and vitiligo, as well as many others. It can take place in a clinical setting or be prescribed for use in the patient's home. For best results, phototherapy treatments need to occur about three times a week for several weeks to months depending on the disease. Home phototherapy is popular because it is easy for patients to maintain consistency in their treatment schedule

Most phototherapy performed today uses Narrowband UVB. This is the most therapeutic band of light and treatments are quite brief, typically just seconds to minutes in duration! Patients simply expose the affected skin to the light - there is no need for other drugs or medications. Once the treatment is over, patients can go about their day as normal.

HOW MUCH DOES THIS COST?

The program is provided to you at a substantial discount, or in some cases AT NO COST!

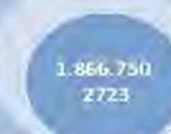
WHAT ARE THE RISKS?

Contrary to other therapies, phototherapy can be prescribed for many types of patients. Pregnant women, children, the elderly, and those with compromised immune systems can all benefit from this safe and effective treatment. Side effects are mild and temporary. Examples are dry skin, itching, or occasional erythema.

IF YOU WISH TO PARTICPATE:

Discuss this option with your physician and then contact AGA at 1-800-888-6472 to start the process!

Value Added Programs



Managed Care Concepts Well Managed Chronic Care Program

What is it?

Managed Care Concepts Chronic Care Program is a set of coordinated services designed to help members manage chronic conditions. For example, some conditions targeted include Asthma, Diabetes, Hypertension, Congestive Heart Failure, Coronary Artery Disease and/or Obesity. The program includes the following:

- Individual Private and Confidential Telephonic Coaching by trained Managed Care Concepts nurse coaches.
- Unlimited inbound calls to your nurse coach.
- Educational Materials mailed or emailed to you.
- Coordination of health services with your Dr and/or other healthcare providers.

The program is 100% confidential, not shared with your employer, and is provided AT NO ADDITIONAL COST to you.

How do I participate?

Managed Care Concepts Chronic Care Program is strictly voluntary. However, it has been proven that there are many benefits to the member for participating. For example, the above conditions with good self-management have been shown to produce a positive impact on the health of an individual, lower health care costs and increase quality of life. Remember, this program does not cost you any additional money. It is provided to you by your employer as a health benefit. If you choose to participate, please follow these easy steps:

1. Call our toll-free number 1-866-750-2723 and ask to speak to a chronic care nurse manager to sign up.

2. IF you wish to participate in the program, you will have a confidential conversation with your Managed Care Concepts Chronic Care Nurse Coach regarding your chronic condition and any questions, concerns, and needs you may have.

Managed Care Concepts Well Managed Chronic Care

Value Added Programs

1.866.750.
2723

3. The nurse will coordinate with your Dr on his plan of care for your chronic condition.
4. Work with your chronic care nurse to set realistic goals you feel comfortable with and can accomplish in a realistic time frame.
5. Talk with your chronic care nurse and discuss how they can help assist you in achieving your goals to better health.
6. Your chronic care nurse will continue to provide you with a wide range of educational resources for your unique condition/s including recipes, exercise, wellness and medical information.
7. Your chronic care nurse is equipped and willing to help you in your journey towards better health, including providing you with a knowledgeable and positive support system and monitoring your progress.

Call us now to start your journey to better health!

Managed Care Concepts Well Managed Chronic Care

2

Value Added Programs

Contact EPIC
EPIC Hearing Healthcare
3191 W. Temple Ave. Ste 200
Pomona, CA 91768

Toll Free
1 866.956.5400

Hearing impaired:
Call **711** national relay service

FAX **909.348.0073**
hear@epichearing.com
www.epichearing.com

YOUR HEARING SERVICE PLAN
and How to Use It

HEAR BETTER • LIVE FULLY

Hearing is one of the five natural senses that allow us to enjoy life and the world around us. Music, radio, television, movies, and theater – all become less accessible and enjoyable without the benefits of hearing. And Hearing Loss can lead to more serious problems such as social disengagement, increased stress and even cognitive decline.

Hearing is a valued life asset that can be protected, treated and assisted through a program for hearing healthcare. The EPIC Hearing Service Plan provides easy access to hearing health professionals – primarily physicians and audiologists – who can help you achieve your maximum hearing potential throughout your life.

Hearing loss usually occurs gradually, without pain or discomfort. However, some more serious symptoms merit immediate attention by a physician:

- A sudden hearing loss
- Spinning and dizziness with vomiting
- Persistent ringing in one ear
- Blood or fluid draining from one or both ears
- Persistent pain in one or both ears

Hearing problems are fairly common: 12% of the US population has some form of hearing impairment and hearing loss is the #3 chronic health problem in the country.
Source: National Institutes of Health

EPIC's National Network Ensures Savings

EPIC's Hearing Service Plan offers you a national alliance of independent ear physicians and audiologists dedicated to high-quality hearing care.

Your EPIC benefit ensures substantial savings – between 30% and 60% – on name-brand hearing aids and products to protect and improve your hearing.

When to Call EPIC

If you experience any of the following, you may have a hearing problem that needs attention:

- **Difficulty understanding voices and words (especially those of women and children)**
- **Occasional ringing in one or both ears**
- **Itching in the ear canals**
- **Difficulty understanding in noisy situations**
- **Turning up the television volume to understand the dialogue**

How Often Should Your Hearing Be Checked?

Hearing tests should be part of your regular health maintenance plan. Hearing professionals recommend testing as follows:

Children 5 – 18	Every two years
Ages 20 – 50	Every two years
Ages 50 +	Annually
Everyone	Anytime you have a concern

The EPIC 5-Step Plan

Any symptom of hearing loss deserves expert evaluation and treatment by a trained hearing health care specialist.

The EPIC Hearing Service Plan starts with an evaluation of your ears and your hearing. Diagnostic tests and measures will determine the course of treatment most likely to help you hear better. The EPIC Hearing Plan's 5 Basic Steps to Good Hearing include:

STEP	
1	**Pure Tone Hearing Test** to determine if a hearing problem exists.
2	**Functional Assessment** to determine the magnitude of the problem and the technology best suited to treat it.
3	**Hearing Aid Evaluation** to determine your ability to wear a hearing aid and select the best model and make.
4	**Fitting and Programming** your hearing aid.
5	**Therapy and Training** to fine-tune your device and maximize the benefits you receive.

How the EPIC Plan Works

- **Call EPIC today to start your hearing program.**
- **A hearing counselor will register you and assist in determining your hearing care needs.**
- **You will receive a Hearing Service Plan booklet outlining all plan services and pricing.**
- **A hearing counselor will coordinate a referral to a provider located near your home or work.**
- **Contact the provider; follow through with an appointment, examination and treatment.**
- **EPIC will coordinate and manage all payments, and assist you in coordinating insurance benefits or coverage when applicable.**
- **Our hearing counselors are available to help you, and to provide advice or additional information.**

Call EPIC at
866.956.5400
Call today to access hearing health services
Hearing impaired:
Dial 711 national relay service

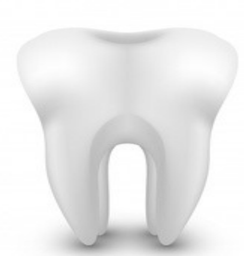
Dental

Administered by:

Your dental health is an important part of your overall health. The City of Fort Wayne offers eligible employees and their dependents a comprehensive dental insurance plan administered by Automated Group Administration (AGA).

	Dental Plan
PLAN FEATURES	
Deductible, per calendar year *Does not apply to Preventive Services*	$50 Individual $150 Family
Annual Maximum Benefit	$1,200 per covered person
COVERED SERVICES	
Preventive Services Up to two dental exams per calendar year, 4 bitewing x-rays per calendar year, 1 full mouth x-ray in 3 continuous calendar years	100%
Basic Services Amalgam, synthetic or plastic fillings, extractions, cysts & neoplasms, root canals, non-surgical treatment for diabetes of gums and mouth tissues	90%
Major Services Inlays, gold fillings, crowns, dentures and precision attachments, fixed bridgework, surgical treatments for disease of gums and mouth tissues	60%
Orthodontia Services	Not covered

Several studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body - including your heart. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.



Voluntary Vision

City of Fort Wayne

Vision Benefit Summary

Customer Service: **800-638-3120**
Provider Locator: **800-839-3242**
www.myuhcvision.com

UnitedHealthcare Vision has been trusted for more than 40 years to deliver affordable, innovative vision care solutions to the nation's leading employers through experienced, customer-focused people and the nation's most accessible, diversified vision care network.

In-network, covered-in-full benefits (after applicable copay) include a comprehensive exam, eye glasses with standard single vision, lined bifocal, or lined trifocal lenses, standard scratch-resistant coating[1] and the frame, or contact lenses in lieu of eye glasses.

Rates	
Employee	$6.76 Monthly
Employee + Spouse	$13.19 Monthly
Employee + Child(ren)	$13.87 Monthly
Employee + Family	$21.30 Monthly
Copays for in-network services	
Exam	$10.00
Materials	$25.00
Benefit frequency	
Comprehensive Exam	Once every 12 months
Spectacle Lenses	Once every 12 months
Frames	Once every 24 months
Contact Lenses in Lieu of Eye Glasses	Once every 12 months
Frame benefit	
Private Practice Provider	$130.00 retail frame allowance
Retail Chain Provider	$130.00 retail frame allowance
Lens options	
Standard scratch-resistant coating -- covered in full. Other optional lens upgrades may be offered at a discount. (Discount varies by provider.)	
Contact lens benefit	
Covered-in-full elective contact lenses [a] The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full (after copay). If you choose disposable contacts, up to 4 boxes are included when obtained from a network provider. **All other elective contact lenses** A $125.00 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside the covered selection (materials copay does not apply). Toric, gas permeable and bifocal contact lenses are examples of contact lenses that are outside of our covered contacts. **Necessary contact lenses**[3] Covered in full after applicable copay.	
Out-of-network reimbursements up to (Copays do not apply)	
Exam	$40.00
Frames	$45.00
Single Vision Lenses	$40.00
Bifocal Lenses	$60.00
Trifocal Lenses	$80.00
Lenticular Lenses	$80.00
Elective Contacts in Lieu of Eye Glasses[2]	$125.00
Necessary Contacts in Lieu of Eye Glasses[3]	$210.00
Laser vision benefit	
UnitedHealthcare Vision has partnered with the Laser Vision Network of America (LVNA) to provide our members with access to discounted laser vision correction providers. Members receive 15% off usual and customary pricing, 5% off promotional pricing at over 500 network provider locations and even greater discounts through set pricing at LasikPlus locations. For more information, call 1-888-563-4497 or visit us at www.uhclasik.com.	

Voluntary Vision

Sample Illustration of Savings				
Cost	**Employee**	**Employee + One**	**Employee + Child(ren)**	**Employee + Family**
Annual Premium	$78.72	$153.72	$161.64	$248.16
Approx. Pre-Tax Savings (20%)[4]	$15.74	$30.74	$32.33	$49.63
Annual Tax-Adjusted Premium	$62.98	$122.98	$129.31	$198.53
Plus Copays	$35.00	$70.00	$105.00	$140.00
Total Cost to Employee	**$97.98**	**$192.98**	**$234.31**	**$338.53**

Exam and Materials Covered by UnitedHealthcare Vision Plan	Estimated Cost Without a Vision Plan[5]	Less Employee Cost	Total Savings with UnitedHealthcare Vision
Employee Exam, Single Vision & Covered-in-Full Frames	$275.00	$97.98	$177.02
Employee + One Exam, Single Vision & Covered-in-Full Frames	$550.00	$192.98	$357.02
Employee + Child(ren)[6] Exam, Single Vision & Covered-in-Full Frames	$825.00	$234.31	$590.69
Employee + Family[7] Exam, Single Vision & Covered-in-Full Frames	$1,100.00	$338.53	$761.47

[1] On all orders processed through a company owned and contracted Lab network.

[2] The out-of-network reimbursement applies to materials only. The fitting/evaluation is not included.

[3] Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following post cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with spectacle lenses; with certain conditions of anisometropia; with certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare Vision confirming reimbursement that UnitedHealthcare Vision will make before you purchase such contacts.

[4] Actual tax savings will depend upon your individual tax bracket.

[5] Approximate retail value illustrated: Exam & Refraction ($65), Single Vision Lenses ($80), and Frames ($130). Average retail costs may vary by provider.

[6] For purposes of this calculation, Employee + Child(ren) is calculated with three (3) members.

[7] For purposes of this sample calculation, Employee + Family is calculated with four (4) members.

[8] Coverage for Covered Contact Lens Selection does not apply at Walmart or Sam's Club locations. The allowance for non-selection contact lenses will be applied toward the fitting/evaluation fee and purchase of all contacts.

Important to Remember:

- Benefit frequency based on last date of service.
- Your $125.00 contact lens allowance is applied to the fitting/evaluation fees as well as the purchase of contact lenses. For example, if the fitting/evaluation fee is $30, you will have $95.00 toward the purchase of contact lenses. The allowance may be separated at some retail chain locations between the examining physician and the optical store.
- You can log on to our website to print off your personalized ID card. An ID card is not required for service, but is available as a convenience to you should you wish to have an ID card to take to your appointment.
- Out-of-Network Reimbursement, when applicable: Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement. Receipts must be submitted within 12 months of date of service to the following address: UnitedHealthcare Vision Attn. Claims Department P.O. Box 30978 Salt Lake City, UT 84130 FAX: 248.733.6060.
- At a participating network provider you will receive a 20% discount on an additional pair of eyeglasses or contact lenses. This program is available after your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UnitedHealthcare Vision shall neither pay nor reimburse the provider or member for any funds owed or spent. Not all providers may offer this discount. Please contact your provider to see if they participate. Discounts on contact lenses may vary by provider. Additional materials do not have to be purchased at the time of initial material purchase. Additional materials can be purchased at a discount any time after the insured benefit has been used.

Please note: If there are differences in this document and the Group Policy, the Group Policy is the governing document. Please consult the applicable policy/certificate of coverage for a full description of benefits, including exclusions and limitations.

The following services and materials are excluded from coverage under the Policy: Post cataract lenses; Non-prescription items; Medical or surgical treatment for eye disease that requires the services of a physician; Worker's Compensation services or materials; Services or materials that the patient, without cost, obtains from any governmental organization or program; Services or materials that are not specifically covered by the Policy; Replacement or repair of lenses and/or frames that have been lost or broken; Cosmetic extras, except as stated in the Policy's Table of Benefits.

UnitedHealthcare Vision coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06.TX and associated COC form number VCOC.INT.06.TX.

UnitedHealthcare

www.myuhcvision.com

Customer Service: 800-638-3120

TDD for Hearing Impaired: 1.800.524.3157

Provider Locator: 1.800.839.3242

Vision Benefit Card

UnitedHealthcare

City of Fort Wayne

Exam	Once every 12 months
Lenses	Once every 12 months
Frames	Once every 24 months
Contacts* *(in lieu of lenses & frames)	Once every 12 months
Exam Copay	$10.00
Materials Copay	$25.00

To print a personalized ID card, please logon to our website and select 'Print ID card' from the member benefits page.

Voluntary Vision

A change to your frame benefit is in sight

Starting January 1, 2011, we're making our frame allowance easier for our members to understand and use.

- Members will have an allowance that will be applied toward the retail purchase price of the frames they choose from any network provider — at both private practice and retail locations! Members can control exactly how much they want to spend on their frames with no guesswork or need for their doctor to determine the price.
- Many providers will also offer an additional discount off any overage on the frame prices if the member chooses a frame that exceeds his or her allowance.*
- Our new program allows for added flexibility in finding the right level of frame benefit for your employees.

We've simplified our frame benefit to make it easier to understand and see the savings.

Understanding exactly how much our members will pay is easy. Since the frame allowance is applied to the retail price of the frame, there is no guess work in how much our members have to spend. If the frame costs less than the allowance, the member has no additional out of pocket expense, other than applicable copay. If the member selects a frame that costs more than their allowance, the member would be responsible for the additional amount above the allowance, plus any applicable copay, less any additional discount available from selected providers.*

Example:

Sally selects frames that cost $149.00. She has a retail frame allowance of $130.00. We have negotiated with the provider to offer a 30% discount on material costs above the frame allowance. So, Sally pays $13.30 for the cost of her frames plus any copay.*

Cost of Frames	$149.00
Less the Retail Frame Allowance	$130.00
SUBTOTAL	$19.00
***Less 30% Additional off the Difference**	$6.70
TOTAL COST FOR FRAMES	**$13.30**

The retail frame allowance is applied to any frame the member would like to purchase at our network locations. There are no limitations to a certain collection or special selection of frames, members just go in to their network provider, shop for what they like and apply their frame allowance to the cost, it's that easy!

We put the power to choose in our members' hands.

**30% Discount available at participating network provider locations.*

UnitedHealthcare Vision®

UnitedHealthcare Vision® coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, or its affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06 and associated COC form number VCOC.INT.06.TX.

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Voluntary Vision

Contact lens benefit

UnitedHealthcare Vision

The difference is clear.

With UnitedHealthcare Vision, members can receive a covered-in-full contact lens benefit (after applicable copay). Coupled with a large national provider network that is made up of private practice and retail providers, the difference is clear.

UnitedHealthcare Vision's contact lens benefit at network providers

UnitedHealthcare Vision's contact lens benefit covers in full (after applicable copay) the fitting/evaluation fees, many popular contact lenses, including disposables, and up to two follow-up visits. Examples of covered contact lenses include brands such as Acuvue® Advance™ with Hydraclear™ by Johnson & Johnson and O_2OPTIX™ by CIBA Vision.

Members who select contact lenses outside of the covered-in-full selection will receive an allowance towards the fitting/evaluation fees and purchase of the contact lenses (materials copay does not apply).

Once members have received their prescription for contact lenses from their eye care provider, they can utilize the online discount ordering program we offer through Vision Direct, an online retailer of contact lenses. Members receive an additional discount off Vision Direct's already low prices and earn Vision Reward points to use towards future purchases when accessed through www.myuhcvision.com.

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UnitedHealthcare Vision®

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Voluntary Vision

UnitedHealthcare Vision
Additional Materials Discount Program

Why stop with just one pair...

At UnitedHealthcare Vision, we understand that you want quality eyewear at an affordable price. Now you can save money on additional pairs of eyeglasses or contacts with our Additional Materials Discount Program. Maybe you can't decide on just one frame, or would enjoy a pair of prescription sunglasses to match your active lifestyle, or perhaps you need safety eyewear for your worksite — you now have that flexibility.

Take advantage of generous savings at network providers

Our standard vision benefit just got better with the addition of our new Additional Materials Discount Program. At a participating network provider,[1] you will receive a 20% discount on an additional pair of eyeglasses or contact lenses.[2] Since the average retail pair of eyeglasses costs about $218, you may save about $44.

The discount on additional materials is taken from the provider's retail price. Furthermore, additional materials do not have to be purchased at the time of initial material purchase. Additional materials can be purchased at a discount any time after the insured benefit has been used.

Contact us today

To find a participating provider in your area, or to learn more about our new Additional Materials Discount Program, call 1.800.638.3120.

[1] Not all providers may offer this discount. Discounts on contact lenses may vary by provider. Please contact your provider to see if they participate.
[2] Once all of your vision benefits have been exhausted.

Please note that this discount shall not be considered insurance, and that UnitedHealthcare Vision shall neither pay nor reimburse the provider or member for any funds owed or spent.

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UnitedHealthcare Vision

Voluntary Vision

Provider network

UnitedHealthcare Vision®

There's always a provider in sight.

One size does not fit all. That's why we created a network that features both private practice and retail providers to allow you a choice for your eye care. Some people prefer the personal service of a private practice provider, especially if they have a longstanding relationship with a family eye doctor. Others prefer the convenience of a retail chain provider. UnitedHealthcare Vision offers a diverse network of over 31,000 providers, including both private practice and leading retail chain providers. Our network allows you to pick the doctor that matches your lifestyle and eye care needs.

In addition to our many private practice doctors, UnitedHealthcare Vision partners with more than 100 national retail chains throughout the country. In fact, UnitedHealthcare Vision's network includes more than half of the top 50 retail chains in the country.[1]

Simply log on to www.myuhcvision.com to locate a provider near you.

Contracted retail chain providers*

ABBA Eyecare
Advance Eyecare Center
Allegany Optical
Alvernon Optical
American Vision Center
America's Best Contacts & Eyeglasses
Bard Optical
Binyon's
Bizer's
Brown's Optical
C & B Optical One
Cambridge Eye Doctors
Co/op Optical
Colony Opticians
Columbia Presbyterian Opticians
Connersville Eye Center
Crown Optical
Cunningham Optical One
Davis Duehr Dean Doctors On Sight
Doctor's Value Vision
Doctor's Vision Works
Dr. Tavel Optical
Duling Optical
ECCA
Empire Vision Center
Enfield Opticians
Exact Eye Care
Eye Boutique
Eye Care Associates
Eye Care in Salem
Eye Care One
Eye Care Plus
Eye Doctors Optical Outlets
Eye Drx
Eye Mart
eyecarecenter, ODPA
Eyeglass World
Eyemart Express
EyeMart Optical
Eyemasters
Eyes First
FirstSight Vision Service
For Eyes
Fritz & Hawley Vision Center, Inc.
General Vision Services
H. Rubin
Halpern Eye Associates
Harley Henion Optician, Inc.
Harvey & Lewis
Heartland Vision
Henry Ford OptimEyes
Herslof Optical
Horizon Eyecare
Horner-Rausch Optical
Hour Eyes
Inno Vision
Jack Kahn's Westgate VisionCenter
Kennedy & Perkins Opticians
Kent Optical
Leitchfield Eye Care
Longe Optical
Louisville Optometric Centers
Mid-West Eye Consultants
Midwest Vision Centers
Monfried Optical
My Eye Dr.
National Optometry
Nationwide Vision
O.H. Gerry Optical
One Hour Optical
Optical Fashions
Optitech
Optiview
Optivision
Ossip Optometry
Page Optical
Park Lane Eye Care
Portland Eye Center
Professional Opticians
Real Optics
Riverfront Optical
Rose Optical One
Rosin Eyecare
Rx Optical
Sam's Club
Schaff Vision Care
See, Inc.
Sharon Optical
Shawnee Optical
Shopko
Singer Optical
Site for Sore Eyes
Smeelink Optical
Standard Optical
Stein Optical
Sterling & Cohen's
SVS Vision
Texas State Optical
The Eye Center Group
The Optical Center
The Optical Shoppe
Thoma Sutton Optical
United Optical
Vision Care Plus
Vision Center II
Vision City
Vision First
Vision Mart
Vision Point
Vision Works
Vision World
Vogue Vision Center
Walsh & Massari of Meriden
Whylie Eye Care
Winchester Eye Center
Wisconsin Vision
Wise Eyes Optical
Younkers Vision Center
Walmart

* Please visit our Web site at www.myuhcvision.com or call UnitedHealthcare Vision's provider locator at 1 800 839 3242 for the most up-to-date list of participating providers. Although UnitedHealthcare Vision contracts with each of these retail chain providers, not all locations within each retail chain participate in UnitedHealthcare Vision's network.

[1] Vision Monday, May 2008

For information, contact a sales representative or visit www.myuhcvision.com.

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UnitedHealthcare Vision®

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Voluntary Vision

Your vision benefit just became clearer.

UnitedHealthcare Vision is pleased to announce that we now offer the ability to print personalized ID cards from our website. The UnitedHealthcare Vision benefit is still paperless. It is not necessary to have an ID card for service, but we know through member feedback that many members are accustomed to using an ID card, so now an ID card is available for your convenience.

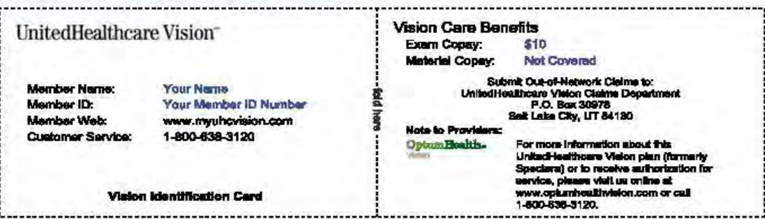
Your ID card will be personalized with your name, member ID, as well as your exam and materials co-pay amounts.

Print your ID card today. It's quick and easy.

HOW TO ACCESS YOUR ONLINE ID CARD:

1 – Go to **myuhcvision.com**
2 – Log in
3 – Click on: "Click Here to Print Vision ID Card"
4 – This generates a pdf with your personal benefit information
5 – Print. *(It's that easy!)*

SAMPLE PERSONALIZED ID CARD



UnitedHealthcare Vision™

Member Name: Your Name
Member ID: Your Member ID Number
Member Web: www.myuhcvision.com
Customer Service: 1-800-638-3120

Vision Identification Card

fold here

Vision Care Benefits
Exam Copay: $10
Material Copay: Not Covered

Submit Out-of-Network Claims to:
UnitedHealthcare Vision Claims Department
P.O. Box 30978
Salt Lake City, UT 84130

Note to Providers:
OptumHealth. Vision
For more information about this UnitedHealthcare Vision plan (formerly Spectera) or to receive authorization for service, please visit us online at www.optumhealthvision.com or call 1-800-638-3120.

UnitedHealthcare Vision®

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7/2010 20115

Life and Accidental Death & Dismemberment

Life/AD&D Insurance provides an important source of income and financial security for your loved ones in the event of your death. The City of Fort Wayne provides eligible employees with Life and Accidental Death & Dismemberment (AD&D) insurance at **no cost to you**. Life/AD&D and Dependent Life insurance benefits are provided through Symetra Life Insurance.

	Employee Life/AD&D Insurance
Class 1: All Active Members of the Patrolmen's Benevolent Association (PBA)	Life: 1 x BAE* up to $150,000 maximum benefit AD&D: 3 x BAE* up to $350,000 maximum benefit
Class 2: All Active Firefighters	Life: 1 x First Class Firefighters annual earnings up to $150,000 maximum benefit AD&D: 1 x First Class Firefighters annual earnings up to $150,000 maximum benefit
Class 3: All Active Members of the Fraternal Order of Police (FOP)	Life: 1 x BAE* plus longevity bonus up to $150,000 maximum benefit AD&D: 3 x BAE* plus longevity bonus up to $450,000 maximum benefit
Class 4: All Other Active Employees	Life: 1 x BAE* up to $150,000 maximum benefit AD&D: 1 x BAE* up to $150,000 maximum benefit
Accelerated Death Benefit	This benefit permits you to take an advance payment of up to 80% of your life insurance benefit, not to exceed the maximum of $500,000 should you become terminally ill (life expectancy of less than 12 months).
Plan Features	Seatbelt(s) and Air Bag Benefit, Repatriation Benefit, Child Education Benefit, Day Care Benefit, Rehabilitation Benefit, Spouse Education Benefit, Adaptive Home & Vehicle Benefit, Conversion, Portability, Waiver of Premium

* *Base annual earnings (BAE)*

It's important to keep your Beneficiary Designation up-to-date. Please see your Human Resources Department should you need to make changes.

Voluntary Life and Accidental Death & Dismemberment

The amount of life insurance protection you need is a personal decision - one that depends on your age, your obligations, and whether you have dependents. That is why the City of Fort Wayne provides you the opportunity to purchase additional Life/AD&D insurance for yourself, spouse and children. Voluntary Life/AD&D insurance benefits are offered through Symetra Life Insurance.

	Employee Life/AD&D Insurance
Employee Life Benefit	You may purchase from $10,000 to $500,000 in increments of $10,000
Employee AD&D Benefit	You may purchase from $10,000 to $500,000 in increments of $10,000
Guarantee Issue Amount	$200,000

	Spouse Life/AD&D Insurance
Spouse Life Benefit	You may purchase from $5,000 to $250,000 in increments of $5,000, not to exceed 50% of employee amount.
Spouse AD&D Benefit	You may purchase from $5,000 to $250,000 in increments of $5,000, not to exceed 50% of employee amount.
Guarantee Issue Amount	$30,000

	Child(ren) Life/AD&D Insurance
Child(ren) Life Benefit *(birth to age 26)*	You may purchase from $2,000 to $10,000 in increments of $2,000
Child(ren) AD&D Benefit *(birth to age 26)*	You may purchase from $2,000 to $10,000 in increments of $2,000
Guarantee Issue Amount	$10,000

Plan Features:

* In order to purchase Life and AD&D coverage for your spouse, and/or child(ren), you must purchase Life and AD&D coverage for yourself.
* Accelerated Life Benefit · Seat Belt & Air Bag Benefit · Child Education Benefit · Day Care Benefit · Repatriation Benefit · Spouse Education Benefit · Adaptive Home and Vehicle Benefit · Waiver of Premium · Conversion · Portability

If you and your eligible dependents do not enroll within 31 days of your eligibility date, you can apply for coverage only during an annual open enrollment period and will need to furnish Evidence of Insurability for the entire amount of coverage.

Disability Insurance

Short Term Disability (STD) benefits provide a source of income should an illness or injury interfere with your ability to work. Even a few weeks away from work can make it difficult to manage household costs. The City of Fort Wayne provides STD to all eligible employees (police/fire excluded) **at no cost to you.** STD insurance is provided through Symetra Life Insurance.

	Short Term Disability Insurance
Benefit	The plan will pay 60% of your weekly earnings if you are unable to work because of a non-occupational injury or sickness. The maximum weekly benefit payable is $1,500.
Elimination Period	Benefits begin on the 8th day for a disability due to an accident or sickness.
Maximum Benefit Period	The maximum number of weeks that benefits are payable for a period of disability is 12 weeks.
Plan Features	Pregnancy is covered the same as any other illness.

Long Term Disability (LTD) provides financial protection in the event that an illness or injury prevents you from being able to work for an extended period of time. The City of Fort Wayne provides Long Term Disability insurance to all eligible employees (police/fire excluded) **at no cost to you.** LTD insurance is provided through Symetra Life Insurance.

	Long Term Disability Insurance
Benefit	The plan will pay 60% of your earnings to a maximum monthly benefit of $5,000 should you become disabled due to an injury or sickness.
Elimination Period	The later of 90 days after the date disability begins or the date accumulated sick leave or the date salary continuation ends or the date short term disability payments to you end
Maximum Benefit Period	Benefits are payable up to Social Security Normal Retirement Age (SSNRA)
Plan Features	Survivor Benefit, Return to Work Benefit, Workplace Modification Benefit, Vocational Rehabilitation Program, Waiver or Premium, Portability.

Value Added Benefits

Symetra Support

Whether you're managing a loved one's final affairs, are in need of assistance while traveling, or looking for guidance on how to resolve identity theft, Symetra Support services offered through your group coverage provides direct assistance when you need it most.

Value Added Benefits

Travel Assistance

Peace of mind while you travel in over 180 countries

Identity Theft Assistance

Security for your finances with timely fraud resolution

Beneficiary Assistance

Relief and support during a difficult and stressful time

EstateGuidance®

Simplify your estate planning and reduce costs

Travel Assistance, Identity Theft Assistance and Beneficiary Assistance are provided by On Call International and EstateGuidance® is provided by ComPsych®. You have access to these services through your Symetra Group Life Insurance coverage.

Continued >

Value Added Benefits

Travel Assistance

24/7 emergency help

Travel Assistance can give you peace of mind while you're traveling abroad.

Emergencies happen. When they happen far from home, it's comforting to know there's a team of multilingual professionals standing by to help. Travel Assistance offers a variety of 24-hour-a-day services in more than 180 countries and territories worldwide—and each one is just a phone call or live chat away.

Who's eligible for Travel Assistance?

You, your spouse or domestic partner, and your dependents up to age 26 are considered to be eligible for all services provided by Travel Assistance.

You can receive pre-trip information at any time.

All other services take effect when you're on a trip 100 miles or more from home lasting 90 days or less.

Value Added Benefits

Travel Assistance features

Medical assistance and transport services*

- **Medical, mental health, dental and pharmacy referrals:** Referrals are provided upon request in the given geographic area locations, where possible.
- **24-hour nurse help line:** Clinical assessment, education and general health information provided upon request.
- **Medical evacuation:** Emergency medical transportation with medical supervision from one facility to another when deemed medically necessary to receive more appropriate treatment.
- **Medical monitoring:** Provided during hospitalization to determine if care is appropriate or if evacuation is required.
- **Medically necessary repatriation:** Once stabilized and deemed fit to travel, medically necessary transportation is provided to return to place of residence for follow up care or to recover. If discharged and deemed fit to travel unescorted, Travel Assistance can arrange transportation to return to the original location or to home if the reason for travel has ended.
- **Prescription replacement assistance:** Consults with the prescribing physician and, if possible, arrangements to send replacement medication or eyeglasses.
- **Coordination of benefits:** Travel Assistance requests health and travel insurance information and attempts to coordinate benefits during an active assistance case.
- **Repatriation of remains:** In the event of death while traveling, all necessary government authorizations and a container appropriate for transportation will be coordinated and arranged, as well as return home of the remains for burial.
- **Vehicle return:** In the event of a death or medical transport which prevents you and your traveling companions from driving your vehicle home, Travel Assistance will procure a driving service to return your vehicle or fly someone you trust to drive it back home.
- **Emergency pet boarding/return:** If you're traveling with your pets and your medical condition leaves you hospitalized and your pet unattended, Travel Assistance will arrange for your pet's return home or for boarding until your discharge.

Emergency travel assistance services*

- **Emergency travel arrangements for visit by family or friend:** If hospitalized, Travel Assistance will arrange travel and suitable hotel accommodations for a person of choice to join.
- **Return of dependent children:** If dependent(s) are present but left unattended as a result of a medical transportation, hospitalization or death, Travel Assistance will make arrangements to return them home, including a non-medical escort as required.
- **Return of traveling companion:** If a medical emergency or death occurs, Travel Assistance will arrange one-way economy airfare to return a companion to their original departure point.

Other key travel assistance services

- **Pre-trip travel information** including visa, passport, inoculation, immunization requirements, cultural information, embassy and consulate referrals, foreign exchange rates and travel advisories. Get up-to-date information regarding health risks, travel restrictions and weather conditions for destinations worldwide.
- **Emergency message relay** to and from friends, relatives and business associates.
- **24/7 assistance with emergency travel arrangements**, including a change of airline, hotel and car rental reservations, once a trip has started.
- **Help locating and replacing lost or stolen items**, like luggage, documents and personal possessions.
- **Legal services are available** if arrested while traveling internationally or are in need of legal services. Travel Assistance will arrange for an initial telephone consultation with an attorney without charge.
- **Translation assistance:** Interpreters are available via phone for translation needs. On Call will also provide referrals for local interpreters and written translation assistance.

*This is only an outline of the plan's features. All services must be arranged and provided by On Call International. Please review your Description of Coverage carefully to understand all the services available to you as well as any terms, conditions and limitations.

Continued >

Value Added Benefits

Identity Theft Assistance

Direct access to 24/7 support if your identity is stolen

Identity Theft Assistance can help secure your finances and aid in identity theft resolution.

Identity theft is a rising concern and it can happen to anyone. Identify Theft Assistance offers you peace of mind by providing you with step-by-step coaching and assistance to help you resolve identity theft.

Who's eligible for the Identity Theft Assistance?

You, your spouse and your dependents under age 26 (regardless of student status) are eligible for all services provided by Identity Theft Assistance. Identity thefts discovered prior to enrollment in a Symetra Group Life Insurance plan are not eligible for services.

If you think your identity has been stolen

Just pick up the phone—24 hours a day, seven days a week—and call On Call International at **(978) 651-9223** if you're in the U.S. or Canada, or **(833) 808-0253** from anywhere else in the world.

Value Added Benefits

Identity Theft Assistance features

Fraud assistance and credit review

- **Three-bureau fraud alert placement assistance:** Upon your request, the three major credit bureaus will be contacted to inform them your credit cards were lost/stolen so that the incident is reported.

Document replacement and financial assistance

- **Lost wallet assistance:** If your debit/credit cards are lost or stolen, Identity Theft Assistance will contact the bank/credit card companies with you on the phone to alert them that the cards were lost or stolen and could be compromised. They'll also provide information to help you replace lost items such as your driver's license and Social Security card.
- **Lost passport replacement:** In the event your passport is lost or stolen, Identity Theft Assistance will assist you in securing an emergency passport replacement, including locating the nearest consulate or embassy if the loss occurs while you're traveling.
- **Emergency cash advance assistance:** If needed, Identity Theft Assistance will assist you in obtaining cash advances from family or friends.

Tips to remember to protect your identity

- Carry only one or two debit or credit cards.
- Bring only the ID information that you'll actually need.
- Keep your passport safe while traveling—make copies, store it in a safe place, and if stolen or lost, report it immediately.
- Do not carry your Social Security card in your wallet.
- If your purse or wallet is stolen, immediately report it to the police.
- Notify your financial institution if your debit or credit card is lost or stolen.

Continued >

Value Added Benefits

Beneficiary Assistance

A helping hand after a loss

Beneficiary Assistance can offer some relief and support during an already stressful time.

Managing a loved one's final affairs can be overwhelming. The amount of time and effort needed to process the loss and close an estate can make an already stressful time even more difficult. Beneficiary Assistance can offer some relief and provide compassionate guidance to help with paperwork, notifications and the time-consuming details of managing a loved one's final affairs.

Who's eligible for Beneficiary Assistance?

You, your spouse and your dependents up to age 26 (regardless of student status), as well as any beneficiaries named under your group life insurance policy with Symetra, are eligible for all services provided by Beneficiary Assistance.

Value Added Benefits

Beneficiary Assistance features

Empathetic guidance

Dedicated coordinators are available 24/7 to provide compassionate professional assistance to:

- **Answer questions.**
- **Offer guidance** on obtaining death certificates or, if applicable, a Consular Report of Death Abroad documentation.
- **Provide beneficiaries with information** regarding local grief counseling services.
- **Assist beneficiaries** with researching local estate planning and/or probate resources.
- **Provide translation services**, if needed, for non-English speakers.

Funeral home referrals

We understand it can be difficult to know how to handle the death of a loved one. When placed in a situation where you have to find a funeral home, you may feel overwhelmed. That's where Beneficiary Assistance can help. You can rely on the experienced beneficiary assistance coordinators to provide referrals to a local funeral home and to funeral director services, if needed.

If the loss of a loved one occurs during travel, Beneficiary Assistance can also help facilitate communication between sending and receiving funeral homes to help with bringing your loved one home as quickly as possible.

Fraud resolution

A deceased's identity is an attractive target for criminals—and may be relatively easy to obtain. Specialists will help you to take actions to protect your loved one's identity and will lend you a hand if their identity is stolen.

These services include:

- **Three-bureau fraud alert placement assistance:** Assist the beneficiary to report the death and/or to suppress the deceased's credit report and/or request the credit bureaus to freeze/close the account.
- **Help filing a police report**, if fraud has occurred.

You may also call Symetra at 1-877-377-6773 for your beneficiary checklist—a resource guide for additional support after a loved one's death.

Continued >

Value Added Benefits

EstateGuidance®

Planning for the future

EstateGuidance® can simplify the process of planning your estate and save you money.

We understand that drafting a will and a living will can be a complicated and expensive process. EstateGuidance® eliminates the hassle and high costs with a simple, secure and affordable online tool.

A better way to secure your legacy

- **It's fast:** preparation of an online will using EstateGuidance® takes on average less than 60 minutes.
- **It's convenient:** prepare these documents when and where it works for you.
- **It's easy to use:** EstateGuidance® provides step-by-step guidance to simplify the process.
- **It grows with you:** Once you create documents online, you can make unlimited free revisions, as needed, to keep them up-to-date.
- **It's legally binding:** you can rely on these documents to be legally enforceable.

To get started:

Complete an easy-to-understand questionnaire and then print, review, and sign your documents, which are created in real time.

Visit www.EstateGuidance.com

Enter your promotional code: SymetraLife

Choose any of the options in the drop-down menu.

Value Added Benefits

EstateGuidance® features

Decide what documents you need, from a last will and testament, living will, healthcare power of attorney, financial power of attorney, and/or final arrangements for, at most, a minor additional fee.

Last will and testament

$14.99

A last will and testament ("will") is the cornerstone of an estate plan. A will ensures that your assets are distributed in accordance with your wishes after your death. A will also allows you to name an executor and a guardian to take care of your children if they are minors. Printing and mailing is available for an additional $9.99.

Living will and healthcare power of attorney

$14.99

A living will is an advanced directive that documents your wishes regarding medical treatment and nutrition in the event of terminal illness, coma or vegetative state. Printing and mailing of a living will is available for an additional $9.99.

A health care power of attorney, included at no additional cost with a living will, allows you to give a trusted family member or friend the power to make medical decisions on your behalf should you become unable to make such decisions.

Financial power of attorney

No additional cost

A financial power of attorney form allows you, the principal, to name someone else, the agent, to make financial decisions for you.

Final arrangements

$9.99

This document is intended to give your surviving family members, friends, and associates guidance regarding your last wishes and to ensure that they can properly honor your memory. Final arrangements allow you to specify your burial or cremation preferences and personalize your obituary, funeral or memorial service. It leads you through the process by asking thoughtful questions and providing detailed educational resources.

We know that plans may change as you progress through different stages of your life. Be assured that EstateGuidance® will be with you every step of the way. Once you create these documents online, you can make unlimited free revisions, as needed, to keep them up-to-date.

Continued >

Value Added Benefits

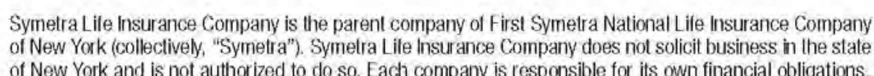
Access your Symetra Support services

To access your On Call Travel Assistance, Identity Theft Assistance and Beneficiary Assistance services:

Just pick up the phone—24 hours a day, seven days a week—and call On Call International at (978) 651-9223 if you're in the U.S. or Canada, or (833) 808-0253 from anywhere else in the world. You may also reach On Call International via text at 1-844-302-5131.

To access your ComPsych EstateGuidance® program:

Visit www.EstateGuidance.com and enter the promotional code **SymetraLife.** Choose any of the options in the drop-down menu.



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In New York, group policies are insured by First Symetra National Life Insurance Company of New York, New York, NY. Mailing address P.O. Box 34690, Seattle, WA 98124.

Travel Assistance, Identity Theft Assistance and Beneficiary Assistance programs are provided by On Call International. EstateGuidance® is provided by ComPsych. Symetra Support may not be available in all states. On Call and ComPsych are not affiliated with Symetra Life Insurance Company or any of its subsidiaries. EstateGuidance® is a registered trademark of ComPsych Corporation.

While Symetra has arranged for your access to these third-party EAP services, Symetra is not responsible for the provision of such services nor are we liable for the failure of the provision of the same. Further, we are not liable to you for the negligent provision of such goods and/or services by third-party service providers.

www.symetra.com
www.symetra.com/ny

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Voluntary Products

Group Hospital Insurance

How does it work?

Group Hospital Insurance helps covered employees and their families cope with the financial impacts of a hospitalization. You can receive benefits when you're admitted to the hospital for a covered accident, illness or childbirth.

Why is this coverage so valuable?

- The money is payable directly to you — not to a hospital or care provider. The money can also help you pay the out-of-pocket expenses your medical plan may not cover, such as co-insurance, co-pays and deductibles.
- You get accessible rates when you buy this coverage at work.
- The cost is conveniently deducted from your paycheck.
- The benefits in this plan are compatible with a Health Savings Account (HSA).
- You may take the coverage with you if you leave the company or retire. You'll be billed directly.

Be Well Benefit

Every year, each family member who has Hospital coverage can also receive $50 for getting a covered Be Well screening test, such as:

- Annual exams by a physician include sports physicals, wellchild visits, dental and vision exams
- Screenings for cancer, including pap smear, colonoscopy
- Cardiovascular function screenings
- Screenings for cholesterol and diabetes
- Imaging studies, including chest X-ray, mammography
- Immunizations including HPV, MMR, tetanus, influenza

Eligibility: All employees not eligible in another group

Who can get coverage?

You:	If you're actively at work.
Your spouse:	Can get coverage as long as you have purchased coverage for yourself.
Your children:	Dependent children newborn until their 26th birthday, regardless of marital or student status

Employee must purchase coverage for themselves in order to purchase spouse or child coverage. Employees must be legally authorized to work in the United States and actively working at a U.S. location to receive coverage.

How much does it cost?

Your semi-monthly premium	
You	$7.50
You and your spouse	$16.11
You and your children	$11.11
Family	$19.72

Coverage may vary by state. See exclusions and limitations.
This plan has a childbirth limitation. See disclosures for more information.
If enrolling, and eligible for Medicare (age 65+; or disabled) the Guide to Health Insurance for People with Medicare is available at https://www.medicare.gov/publications/02110-medigap-guide-health-insurance.pdf

Voluntary Products

Hospital		
Hospital Admission	Payable for a maximum of 1 day per year	$1,000
Hospital Daily Stay	Payable per day up to 365 days	$100
ICU Daily Stay	Payable per day up to 30 days	$200

Exclusions and Limitations

Hospital Insurance filed policy name is Group Hospital Indemnity Insurance Policy. The definition of hospital does not include certain facilities. See your contract for details.

Active employment
You are considered in active employment if, on the day you apply for coverage, you are being paid regularly for the required minimum 30 hours per week and you are performing the material and substantial duties of your regular occupation. Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. New employees have a 30 day waiting period to be eligible for coverage. Please contact your plan administrator to confirm your eligibility date.

Childbirth Limitation
We will not pay benefits due to Childbirth for any Insured within the first nine months after the Insured's Coverage Effective Date.
Childbirth or Complications of Pregnancy will be covered to the same extent as any other Covered Sickness.

Exclusions and limitations
We will not pay benefits for a claim that is caused by, contributed to by, or resulting from any of the following:
- committing or attempting to commit a felony;
- being engaged in an illegal occupation or activity;
- injuring oneself intentionally or attempting or committing suicide, whether sane or not;
- active participation in a riot, insurrection, or terrorist activity. This does not include civil commotion or disorder, injury as an innocent bystander, or injury for self-defense;
- participating in war or any act of war, whether declared or undeclared;
- Combat or training for combat while serving in the armed forces of any nation or authority, including the National Guard, or similar government organizations;
- being intoxicated;
- a Covered Loss that occurs while an insured is legally incarcerated in a penal or correctional institution;
- elective procedures, cosmetic surgery, or reconstructive surgery unless it is a result of organ donation, trauma, infection, or other diseases;
- treatment for dental care or dental procedures, unless treatment is the result of a Covered Accident;
- any Admission or Daily Stay of a newborn Child immediately following Childbirth unless the newborn is Injured or Sick;
- voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician; and
- Mental or Nervous Disorders. This exclusion does not include dementia if it is a result of:
- stroke, Alzheimer's disease, trauma, viral infection; or
- other conditions which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.

Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

End of employee coverage
If you choose to cancel your coverage under this certificate, your coverage will end on the first of the month following the date you provide notification to your Employer.
Otherwise, your coverage under this certificate ends on the earliest of:
- the date the Policy is cancelled by us or your Employer;
- the date you are no longer in an Eligible Group;
- the date your Eligible Group is no longer covered;
- the date of your death;
- the last day of the period any required premium contributions are made; or
- the last day you are in Active Employment.

However, as long as premium is paid as required, coverage will continue in accordance with the Continuation of your Coverage During Absences provision or if you elect to continue coverage for you under Portability of Hospital Indemnity Insurance.
We will provide coverage for a Payable Claim that occurs while you are covered under this certificate.

THIS INSURANCE PROVIDES LIMITED BENEFITS
This coverage is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law. Insureds in some states must be covered by comprehensive health insurance before applying for hospital insurance.
This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form GHIP16-1 and Certificate Form GHIC16-1 or contact your Unum representative.
Unum complies with applicable civil union and domestic partner laws.

Underwritten by: Unum Insurance Company, Portland, Maine
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Voluntary Products

Eligibility: All Employees not eligible in another group

Accident Insurance

How does it work?

Accident Insurance pays a set benefit amount based on the type of injury you have and the type of treatment you need. It covers accidents that occur on and off the job. And it includes a range of incidents, from common injuries to more serious events.

Why is this coverage so valuable?

It can help you with out-of-pocket costs that your medical plan doesn't cover, like co-pays and deductibles. You'll have base coverage without medical underwriting. The cost is conveniently deducted from your paycheck. You can keep your coverage if you change jobs or retire. You'll be billed directly.

Who can get coverage?

You	If you're actively at work*
Your spouse	Can get coverage as long as you have purchased coverage for yourself.
Your children	Dependent children from birth until their 26th birthday, regardless of marital or student status.

*Employees must be legally authorized to work in the United States and actively working at a U.S. location to receive coverage. See Schedule of benefits for a complete listing of what is covered.

How much does it cost?

Your Semi-monthly premium	Option 1
You	$5.41
You and your spouse	$9.64
You and your children	$10.94
Family	$15.18

What's included?

Be Well Benefit

Every year, each family member who has Accident coverage can also receive $50 for getting a covered Be Well screening test, such as:

- Annual exams by a physician include sports physicals, well-child visits, dental and vision exams
- Screenings for cancer, including pap smear, colonoscopy
- Cardiovascular function screenings
- Screenings for cholesterol and diabetes
- Imaging studies, including chest X-ray, mammography
- Immunizations including HPV, MMR, tetanus, influenza

EN-2073 FOR EMPLOYEES (4-22)

Voluntary Products

SCHEDULE OF BENEFITS

Accidental Death and Dismemberment

AD&D	
Employee	$25,000
Spouse	$12,500
Children	$6,250
Common Carrier Benefit can pay if the insured individual is injured as a fare-paying passenger on a common carrier (examples include mass transit trains, buses and planes)	
Employee	$25,000
Spouse	$12,500
Children	$6,250
Dismemberment	
Both Feet	$25,000
Both Hands	$25,000
One Foot	$12,500
One Hand	$12,500
Thumb and Index Finger of the same Hand	$6,250
Coma	
Coma	$5,000
Loss of Use	
Hearing	$12,500
Sight of one Eye	$12,500
Sight of both Eyes	$25,000
Speech	$12,500
Paralysis	
Uniplegia	$6,250
Hemi/Paraplegia	$12,500
Triplegia	$18,750
Quadriplegia	$25,000

Hospitalization

Admission	$1,000
Admission – Hospital ICU	$1,000
Daily Stay (amount)	$200
Daily Stay – Hospital ICU (amount)	$200
Short Stay	N/A
Domestic Steerage	N/A

Injury

Organized Sports	N/A
Burns	
2nd Degree Burns - At least 5%, but less than 20% of skin surface	$500
2nd Degree Burns - 20% or greater of skin surface	$1000
3rd Degree Burns - Less than 5% of skin surface	$2,000
3rd Degree Burns - At least 5%, but less than 20% of skin surface	$5,000
3rd Degree Burns - 20% or greater of skin surface	$10,000
Concussion	
Concussion	$200
Connective Tissue Damage	
One Connective Tissue (tendon, ligament, rotator cuff, muscle)	$90
Two or more Connective Tissues (tendon, ligament, rotator cuff, muscle)	$150
Dislocations	
Knee joint (other than patella)	$1,650
Ankle bone or bones of the foot (other than toes)	$1,650
Hip joint	$3,375
Collarbone (sternoclavicular)	$825
Elbow joint	$500
Hand (other than Fingers)	$500
Lower Jaw	$500
Shoulder	$500
Wrist joint	$500
Collarbone (acromioclavicular and separation)	$325
Finger or Toe (Digit)	$150
Kneecap (patella)	$500
Incomplete Dislocation – Payable as a % of the applicable Dislocations benefit	25%
Eye Injury	
Eye Injury	$200
Fractures	
Skull (except bones of Face or Nose), Depressed	$4,500
Hip or Thigh (femur)	$3,375
Skull (except bones of Face or Nose), Non-depressed	$2,250
Vertebrae, body of (other than Vertebral Processes)	$1,350
Leg (mid to upper tibia or fibula)	$1,350
Pelvis	$1,350
Bones of the Face or Nose (other than Lower Jaw, Mandible or Upper Jaw, Maxilla)	$675
Upper Arm between Elbow and Shoulder (humerus)	$675
Upper Jaw, Maxilla (other than alveolar process)	$675
Ankle (lower tibia or fibula)	$450
Collarbone (clavicle, sternum) or Shoulder Blade (scapula)	$450
Foot or Heel (other than Toes)	$450
Forearm (olecranon, radius, or ulna), Hand, or Wrist (other than Fingers)	$450
Kneecap (patella)	$450
Lower Jaw, Mandible (other than alveolar process)	$450
Vertebral Processes	$450
Rib	$450
Tailbone (coccyx), Sacrum	$450
Finger or Toe (Digit)	$225
Chip Fracture - Payable as a % of the applicable Fractures benefit	25%
Same bone maximum incurred per accident	1 Fracture
Maximum payable multiplier for multiple bones	2 Times
Internal Injuries	
Internal Injuries	$200
Lacerations	
No Repair	$50
Repair Less than 2 inches	$150
Repair At least 2 inches but less than 6 inches	$300
Repair 6 inches or greater	$600
Loss of a Digit	
One Digit (other than a Thumb or Big Toe)	$750
One Digit (a Thumb or Big Toe)	$1,125
Two or more Digits	$1,500
Knee Cartilage	
Knee Cartilage (Meniscus) Injury	$150
Ruptured or Herniated Disc	
One Disc	$150
Two or more Discs	$250

Recovery

At-Home Care	$75
Physician Follow-Up Visits	$50
Physician Follow-Up Maximum Visits	2
Prescription Drug	$25
Prescription Benefit Incidence per covered accident	1 Per Insured
Rehabilitation or Subacute Rehabilitation Unit	$50
Behavior Health Therapy	N/A

Unum | Accident Insurance

Voluntary Products

SCHEDULE OF BENEFITS

Recovery	
Behavior Health Therapy visits	N/A
Therapy Services (chiro, speech, PT, occ)	$25
Therapy Services Maximum Days	15
Surgery	
Dislocations	
Dislocation, Surgical Repair - Payable as a % of the applicable Injury benefit	100%
Anesthesia	
Epidural or Regional Anesthesia	$100
General Anesthesia	$250
Connective Tissue	
Exploratory without Repair	$100
Repair for One Connective Tissue	$800
Repair for Two or more Connective Tissues	$1,200
Eye Surgery	
Eye Surgery, Requiring Anesthesia	$300
Fractures	
Fractures, Surgical Repair - Payable as a % of the applicable Injury benefit	100%
Surgical Repair same bone maximum incurred per accident	1 Fracture
Surgical Repair same bone maximum payable multiplier for multiple bones	2 Times
General Surgery	
Abdominal, Thoracic, or Cranial	$1,500
Exploratory	$150
Incidence per covered accident	1 Per Insured
Hernia Surgery	
Hernia Surgery	$150
Knee Cartilage	
Knee Cartilage (Meniscus) Exploratory without Repair	$150
Knee Cartilage (Meniscus) with Repair	$750
Outpatient Surgical Facility	
Outpatient Surgical Facility	$300
Ruptured or Herniated Disc Surgery	
Exploratory without Repair	$125
One Disc	$675
Two or more Discs	$1,000

Treatment	
Organized Sports	N/A
Ambulance	
Air	$1,500
Ground	$200
Durable Medical Equipment	
Tier 1 (arm sling, cane, medical ring cushion)	$65
Tier 2 (bedside commode, cold therapy system, crutches)	$125
Tier 3 (back brace, body jacket, continuous passive movement, electric scooter)	$250
Emergency Dental Repair	
Dental Crown	$450
Dental Extraction	$150
Filling or Chip Repair	$115
Imaging	
Tier 1: X-rays or Ultrasound	$50
Tier 2: Bone Scan, CAT, CT, EEG, MR, MRA, or MRI	$150
Medical Imaging Incidence allowance covered accident per Tier	1 Per Insured Per Tier
Lodging	
Lodging (per night)	$200
Prosthetic Device	
One Device or Limb	$1,000
Two or more Devices or Limbs	$2,000
Skin Grafts	
For Burns - Payable as a % of the applicable Burn benefit	50%
Not Burns - Less than 20% of skin surface	$375
Not Burns - 20% or greater of skin surface	$750
Treatment	
Emergency Room Treatment	$125
Injections to Prevent or Limit Infection (tetanus, rabies, antivenom, immune globulin)	$50
Pain Management Injections (epidural, cortisone, steroid)	$150
Transfusions	$500
Transportation (per trip)	$150
Family Care	N/A
Pet Boarding (per day)	N/A
Treatment in a Physician's Office or Urgent Care Facility (initial)	$50

Unum | Accident Insurance

Voluntary Products

Active employment

You are considered in active employment if, on the day you apply for coverage, you are being paid regularly for the required minimum 20 hours each week and you are performing the material and substantial duties of your regular occupation. Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. New employees have a 0 day waiting period to be eligible for coverage. Please contact your plan administrator to confirm your eligibility date.
If enrolling and eligible for Medicare (age 65+; or disabled) the Guide to Health Insurance for People with Medicare is available at www.medicare.gov/sites/default/files/2022-03/02110-medigap-guide-health-insurance.pdf.

Effective date of coverage

Coverage becomes effective on the first day of the month in which payroll deductions begin.

Exclusions and limitations

We will not pay benefits for a claim that is caused by, contributed to by, or resulting from any of the following:

- committing or attempting to commit a felony;
- being engaged in an illegal occupation or activity;
- injuring oneself intentionally or attempting or committing suicide, whether sane or not;
- active participation in a riot, insurrection, or terrorist activity. This does not include civil commotion or disorder, injury as an innocent bystander, or injury for self-defense;
- participating in war or any act of war, whether declared or undeclared;
- combat or training for combat while serving in the armed forces of any nation or authority, including the National Guard, or similar government organizations;
- a Covered Loss that occurs while an Insured is legally incarcerated in a penal or correctional institution;
- elective procedures, cosmetic surgery, or reconstructive surgery unless it is a result of organ donation, trauma, infection, or other diseases;
- any Sickness, bodily infirmity, or other abnormal physical condition or Mental or Nervous Disorders, including diagnosis, treatment, or surgery for it;
- infection. This exclusion does not apply when the infection is due directly to a cut or wound sustained in a Covered Accident;
- experimental or investigational procedures;
- operating any motorized vehicle while intoxicated;
- operating, learning to operate, serving as a crew member of any aircraft or hot air balloon, including those which are not motor-driven, unless flying as a fare paying passenger;
- jumping, parachuting, or falling from any aircraft or hot air balloon, including those which are not motor-driven;
- travel or flight in any aircraft or hot air balloon, including those which are not motor-driven, if it is being used for testing or experimental purposes, used by or for any military authority, or used for travel beyond the earth's atmosphere;
- practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received;
- riding or driving an air, land or water vehicle in a race, speed or endurance contest; and
- engaging in hang-gliding, bungee jumping, sail gliding, parasailing, parakiting, or BASE jumping.

The Accidental Death and Dismemberment Benefits are also subject to the following Exclusions. We will not pay benefits for a claim that is caused by, contributed to by, or resulting from any of the following:

- being intoxicated; and
- voluntary use of or treatment for voluntary use of any prescription or non-prescription drug,alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician.]

Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

Termination of employee coverage

If you choose to cancel your coverage your coverage ends on the first of the month following the date you provide notification to your employer. Otherwise, your coverage ends on the earliest of the:

- the date this policy is canceled by Unum or your employer;
- the date you are no longer in an eligible group;
- the date your eligible group is no longer covered;
- the date of your death;
- the last day of the period any required premium contributions are made;
- the last day you are in active employment.

However, as long as premium is paid as required, coverage will continue

- in accordance with the Continuation of your Coverage during Absences provision; or
- if you elect to continue coverage for you, your Spouse, and Children under Portability of Accident Insurance.

We will provide coverage for a Payable Claim that occurs while you are covered under this certificate

Accident Insurance

THIS IS A LIMITED BENEFITS POLICY
This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to certificate form GAC16-1 et al. and GAC16-2, GAC16-2-IL, GAC16-3-NH, GAC16-2-OH, and GAC16-2-UT. Policy Form GAP16-1 et al. in all states, GAP16-3-NH in New Hampshire or contact your Unum representative.
Unum complies with state civil union and domestic partner laws when applicable.

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Voluntary Products

Eligibility: All employees not eligible in another group

Group Critical Illness Insurance

How does it work?

If you're diagnosed with an illness that is covered by this insurance, you can receive a lump sum benefit payment. You can use the money however you want.

Why is this coverage so valuable?

- The money can help you pay out-of-pocket medical expenses, like deductibles.
- You can use this coverage more than once. Even after you receive a payout for one illness, you're still covered for the remaining conditions and for the reoccurrence of any critical illness with the exception of skin cancer. The reoccurrence benefit can pay 100% of your coverage amount. Diagnoses must be at least 180 days apart or the conditions can't be related to each other.

What's covered?

Critical Illnesses	
• Heart attack • Stroke • Major organ failure • End-stage kidney failure	• Coronary artery disease • Major (50%): • Coronary artery bypass graft • or valve replacement • Minor (10%): • Balloon angioplasty or • stent placement

Cancer conditions	
• Invasive cancer — all breast cancer is considered invasive • Non-invasive cancer (25%)	• Skin cancer — $500

Progressive diseases	Supplemental conditions
• Amyotrophic Lateral Sclerosis (ALS) • Dementia, including Alzheimer's disease • Multiple Sclerosis (MS) • Parkinson's disease • Functional loss	• Loss of sight, hearing or speech • Benign brain tumor • Coma • Permanent Paralysis • Occupational HIV, Hepatitis B, C or D Paid at 25% • Infectious Diseases

Why should I buy coverage now?

- It's more accessible when you buy it through your employer and the premiums are conveniently deducted from your paycheck.
- Coverage is portable. You may take the coverage with you if you leave the company or retire. You'll be billed at home.

Be Well Benefit	
Every year, each family member who has Critical Illness coverage can also receive $50 for getting a covered Be Well Benefit screening test, such as:	
• Annual exams by a physician include sports physicals, well-child visits, dental and vision exams • Screenings for cancer, including pap smear, colonoscopy • Cardiovascular function screenings	• Screenings for cholesterol and diabetes • Imaging studies, including chest X-ray, mammography • Immunizations including HPV, MMR, tetanus, influenza

Who can get coverage?

You:	Choose $10,000, $20,000 or $30,000 of coverage with no medical underwriting to qualify if you apply during this enrollment.
Your spouse:	Spouses can only get 50% of the employee coverage amount as long as you have purchased coverage for yourself.
Your children:	Children from live birth to age 26 are automatically covered at no extra cost. Their coverage amount is 50% of yours. They are covered for all the same illnesses plus these specific childhood conditions: cerebral palsy, cleft lip or palate, cystic fibrosis, Down syndrome and spina bifida. The diagnosis must occur after the child's coverage effective date.

Please refer to the certificate for complete definitions of these covered conditions. Coverage may vary by state. See exclusions and limitations.

EN-2050 FOR EMPLOYEES (8-23)

Unum | Group Critical Illness Insurance 916883

Voluntary Products

Age	Employee coverage: $10,000 Spouse coverage: $5,000 Be Well benefit: $50	
	Employee	Spouse
under 25	$1.52	$1.22
25 - 29	$1.82	$1.37
30 - 34	$2.22	$1.57
35 - 39	$2.72	$1.82
40 - 44	$3.62	$2.27
45 - 49	$5.02	$2.97
50 - 54	$7.32	$4.12
55 - 59	$10.12	$5.52
60 - 64	$14.52	$7.72
65 - 69	$21.32	$11.12
70 - 74	$31.77	$16.35
75 - 79	$44.42	$22.67
80 - 84	$61.17	$31.05
85+	$95.97	$48.45

Semi-monthly costs

Age	Employee coverage: $20,000 Spouse coverage: $10,000 Be Well benefit: $50	
	Employee	Spouse
under 25	$2.12	$1.52
25 - 29	$2.72	$1.82
30 - 34	$3.52	$2.22
35 - 39	$4.52	$2.72
40 - 44	$6.32	$3.62
45 - 49	$9.12	$5.02
50 - 54	$13.72	$7.32
55 - 59	$19.32	$10.12
60 - 64	$28.12	$14.52
65 - 69	$41.72	$21.32
70 - 74	$62.62	$31.77
75 - 79	$87.92	$44.42
80 - 84	$121.42	$61.17
85+	$191.02	$95.97

Semi-monthly costs

Age	Employee coverage: $30,000 Spouse coverage: $15,000 Be Well benefit: $50	
	Employee	Spouse
under 25	$2.72	$1.82
25 - 29	$3.62	$2.27
30 - 34	$4.82	$2.87
35 - 39	$6.32	$3.62
40 - 44	$9.02	$4.97
45 - 49	$13.22	$7.07
50 - 54	$20.12	$10.52
55 - 59	$28.52	$14.72
60 - 64	$41.72	$21.32
65 - 69	$62.12	$31.52
70 - 74	$93.47	$47.20
75 - 79	$131.42	$66.17
80 - 84	$181.67	$91.30
85+	$286.07	$143.50

Active employment: You are considered in active employment if, on the day you apply for coverage, you are being paid regularly for the required minimum 30 hours each week and you are performing the material and substantial duties of your regular occupation. Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. New employees have a 30 day waiting period to be eligible for coverage. Please contact your plan administrator to confirm your eligibility date.
If enrolling, and eligible for Medicare (age 65+; or disabled) the Guide to Health Insurance for People with Medicare is available at https://www.medicare.gov/publications/02110-medigap-guide-health-insurance.pdf

EN-2050 FOR EMPLOYEES (8-23) Unum | Group Critical Illness Insurance 916883

Voluntary Products

Your paycheck deduction will include the cost of coverage and the Be Well Benefit. Actual billed amounts may vary.

Exclusions and limitations

We will not pay benefits for a claim that is caused by, contributed to by, or occurs as a result of any of the following:

- committing or attempting to commit a felony; being engaged in an illegal occupation or activity; injuring oneself intentionally or attempting or committing suicide, whether sane or not; active participation in a riot, insurrection, or terrorist activity. This does not include civil commotion or disorder, injury as an innocent bystander, or injury for self-defense; participating in war or any act of war, whether declared or undeclared; combat or training for combat while serving in the armed forces of any nation or authority, including the National Guard, or similar government organizations; voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician; being intoxicated; and a Date of Diagnosis that occurs while an Insured is legally incarcerated in a penal or correctional institution.

Additionally, no benefits will be paid for a Date of Diagnosis that occurs prior to the Coverage Effective Date. Date of diagnosis must be after the coverage effective date.

End of employee coverage

If you choose to cancel your coverage your coverage ends on the first of the month following the date you provide notification to your employer. Otherwise, your coverage ends on the earliest of the: date this policy is canceled by Unum or your employer; date you are no longer in an eligible group; date your eligible group is no longer covered; date of your death; last day of the period any required premium contributions are made; or last day you are in active employment.

However, as long as premium is paid as required, coverage will continue in accordance with the Continuation of your Coverage during Absences provision or if you elect to continue coverage for you, your Spouse, and Children under Portability of Critical Illness insurance.

Unum will provide coverage for a payable claim that occurs while you are covered under this certificate.

Unum complies with applicable civil union and domestic partner laws.

THIS INSURANCE PROVIDES LIMITED BENEFITS

This coverage is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law. Insureds in some states must be covered by comprehensive health insurance before applying for this coverage.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Certificate Form GCIC16-1 and Policy Form GCIP16-1 or contact your Unum representative.

Underwritten by: Unum Insurance Company, Portland, Maine

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Voluntary Products

Give yourself protection for a lifetime

Many people buy life insurance to provide financial protection for those left behind. What if your life insurance could also provide benefits if you suffer from a permanent health condition and you require ongoing care from a family member or professional caregiver?

Value of Whole Life insurance

- **Permanent Life insurance**
- **Living Care benefits for chronic illnesses**
- **Guaranteed premiums and death benefits**
- **Accumulates cash value[1]**
- **Payroll-deducted premiums**
- **Coverage can be taken with you if you change jobs or retire, billed directly to you at home**

Atlantic American's Whole Life & Living Care plan combines the guarantees of permanent life insurance with the l[illegible]ng care protection. Our living care benefits can assis[illegible] need to take care of ongoing expenses that aris[illegible] medical condition.

This hybrid life product is ideal if you want to:

- **Leave a death benefit** to loved ones after you die
- **Provide benefits** for the costly expenses associated with care, particularly over long periods of time
- **Lifelong coverage** through retirement with no increase in premiums

How can Living Care benefits help?

Adult daycare

Assisted living or nursing home

Prescription drugs

Gas for transportation (to and from treatment)

Cash to a family member to assist in your care

[1]Access to cash values through borrowing or partial surrenders will reduce the policy's cash value and death benefit, increase the chance the policy will lapse, and may result in a tax liability if the policy terminates before the death of the insured.

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Voluntary Products

GROUP WHOLE LIFE INSURANCE

The ABC's of **Living Care[1] benefits**

Long-term chronic illnesses can have a significant impact on an individual's quality of life, both physically and financially. These types of illnesses often require ongoing medical treatment and care, which can be costly and financially devastating for individuals and their families. Atlantic American's Whole Life plan allows you to access a portion of your life insurance benefits while living. We call this Living Care.

You may not have a long-term illness now, but let's consider how you may use a hybrid life plan.

Living Care[1] ABC's

Example Election: **Whole Life** $70,000 ▶ **Living Care** 6.25% up to 32 months ▶ **Death Restoration**

A

What if you need care for a long-term illness?

You are able to use our Living Care benefit with a maximum **monthly benefit $4,375,** for up to **32 months.**

When you pass away, your beneficiary still receives a **Death Benefit of 50%,** or **$35,000.**

Use it all and get restored

B

What if you need care for a brief period of time?

You could have a serious illness that leaves you needing care for a brief period. **You use only $28,000** for your care, before passing away.

The remainder of your policy, **$42,000,** is paid to your beneficiary as a **death benefit.**

Use some and leave some

C

You could pass away, without ever needing care

The entire **$70,000** face amount of your policy will be paid as a **death benefit** to your beneficiaries.

Keep it all as a legacy

[1]The Living Care Benefit is an acceleration of the death benefit and is not Long-Term Care Insurance. It begins to pay after 90 days of confinement or services, and to qualify you must meet conditions of eligibility for benefits. Pre-existing condition limitation may apply. Living Benefits may not be available in all states or may be named differently. Please consult your policy for complete details. This hypothetical example does not guarantee or predict actual performance. This is an example for illustrative purposes only. Actual policy amounts and payments will depend on benefits purchased, death and living benefits.

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Voluntary Products

GROUP WHOLE LIFE INSURANCE

Summary of Benefits

Atlantic American Employee Benefits' Group Whole Life insurance plan includes the benefits listed below. Each benefit is subject to conditions for payment as detailed in the certificate.

PLAN INFORMATION

Available To	ISSUE AGES	BENEFIT AMOUNT
Employee	18-70	Up to $100,000 in $10,000 increments
Spouse Coverage*	18-65	Up to $30,000, in $10,000 increments - up to 100% of employee election. Based on spouse age.
Dependent Coverage*	15 days - age 25	$10,000 - up to 100% of employee election. Term rider continues to age 26 at which point they may choose to convert to an individual policy, up to 5x the Child's coverage amount, on a guarantee issue basis.

ADDITIONAL PLAN DETAILS

Portability	Included

RIDERS

Employee	Accelerated Death Benefit for Terminal Illness Rider - Insured can receive up to 50% of elected face amount during their life when there are diagnosed with a terminal illness that leaves them with a life expectancy of 12 months or less.
	Waiver of Premium Rider - Plan premiums are waived during disability period when insured has been disabled for 6 months. Included on issue ages 18-65; terminates at age 70.
	Accelerated Death Benefit for Chronic Illness Rider with Extension of Benefits Rider - Provides a 6.25% monthly benefit, up to 200% of certificate face amount.
	Restoration of Benefits Rider - Restores 50% of the death benefit for the beneficiary in the event the Acceleration for Chronic Illness Rider is exhausted.
Spouse	Accelerated Death Benefit for Terminal Illness Rider
	Accelerated Death Benefit for Chronic Illness Rider with Extension of Benefits Rider - 6.25% monthly benefit, up to 200% of certificate face amount.
	Restoration of Benefits Rider - Restores 50% of the death benefit for the beneficiary in the event the Acceleration for Chronic Illness Rider is exhausted.
Dependent(s)	Children's Term Rider

All benefit amounts are Guarantee Issue

* Employee coverage is required in order to elect spouse and/or dependent coverage.

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Voluntary Products

Exclusions, Limitations and Other Plan Information

GROUP WHOLE LIFE

EXCLUSIONS – No Benefits are provided for the following, nor will We pay any expenses incurred as a result of any Loss which is caused by, or sustained while, or incurred for, directly or indirectly: 1) suicide – If the Insured, whether sane or insane, dies by Suicide, within two (2) years* from the Effective Date, Our liability will be limited to an amount equal to the premiums paid for this Certificate.

* 1 year in CO, MO, ND.

OTHER LIMITATIONS AND EXCLUSIONS – The policy and riders have other elimination periods, exclusions and limitations that may affect coverage. Please refer to your certificate for full details.

DELAYED EFFECTIVE DATE PROVISION – Atlantic American Employee Benefits will postpone the Effective Date of an eligible Spouse/Dependent, other than a newborn child's coverage if, on that date, he or she is: 1) confined to a hospital or other health care facility; 2) home confined; or 3) unable to perform two or more daily living activities. In that case, we will postpone the Effective Date of his or her coverage until the day after the date: (a) of his or her discharge from such facility; (b) his or her home confinement ends; or (c) he or she is no longer requires assistance with two or more activities of daily living. If a Spouse/Dependent was covered under a prior plan at replacement, this language will not apply to the amount of coverage that was in force with the prior plan.

QUALIFYING CHRONIC ILLNESS – a Chronic Illness: 1) that was Diagnosed no more than twelve (12) months prior to the date We received a claim for benefits under this Rider; 2) that has continued while this Rider has been In Force for at least ninety (90) consecutive Days; 3) which was not caused by a mental or nervous disorder (except organically demonstrable disorders, such as Alzheimer's or senile dementia), alcoholism or drug addiction; and 4) which is expected to be Permanent.

PORTABILITY OPTION – If you, an employee, lose eligibility for this insurance, coverage can be continued by paying the premiums directly to us within 31 days after termination. We will bill the employee directly once we receive notification to continue coverage.

COVERED CHILDREN AND GRANDCHILDREN – Children are covered if the child is a natural, step, or legally adopted child and dependent of the employee. A grandchild is covered if the child is a dependent of the employee and filed as such on their federal tax returns. Children/grandchildren must reside in the U.S. to receive coverage.

CONVERSION – Within the 31-day period after the expiration date of the term insurance on each Dependent Child, such term insurance may be converted to a new whole life policy without evidence of insurability up to 5x the term rider coverage amount.

EXPIRATION OF CHILDREN TERM INSURANCE – The term insurance on each Dependent Child will expire on the earlier of 1) the end of the month of the child's 26th birthday; or 2) the date the Certificate matures or becomes paid up for its full Face Amount.

Voluntary Products

GROUP WHOLE LIFE INSURANCE

chance that someone turning 65 will need long-term care services in their remaining years.

https://bit.ly/3uTPdxs

Group Whole Life policy form series B 21803 GMP, Accelerated Death Benefit Rider for Terminal Illness form B 21803 R1 ACL, Accelerated Death Benefit Rider for Chronic Illness form B 21803 R12 CIACL, Restoration of Benefits Rider for Chronic Illness form B 21803 R13 ROBCI, Extension of Benefits Rider form B 21803 R14 EOBR, Children's Term Insurance Rider form B 21803 R8 CTR, Waiver of Premium for Disability Rider form B 21803 R9 WPD, and Accidental Death and Dismemberment Rider form B 21803 R10 ADD underwritten by Bankers Fidelity Life Insurance Company®. Limitations and exclusions apply; the terms and conditions in the actual policy and certificate provisions control. Refer to the specific policy and certificate for details. Application to determine eligibility may be required. The Policy, any optional Riders and the benefits therein are subject to availability and may vary by state. This is only a summary of products and services offered; actual offerings may vary by group size and other underwriting or legal considerations. This is a solicitation of insurance and an independent agent may call on you.

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Easy access to coverage

MyCoverage is an easy-to-use website that allows you to access coverage and benefit information 24/7, update your profile and more.
mycoverage.atlam.com

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Health Reimbursement Account (HRA) - Dental & Vision

HEALTH REIMBURSEMENT ACCOUNT
DENTAL & VISION SERVICES

1. What is a health reimbursement account (HRA)?

The City of Fort Wayne is offering a health reimbursement account (HRA) for 2023 for dental and vision expenses. An HRA is an IRS-approved, tax-advantaged benefit plan that reimburses employees for out-of-pocket expenses. This benefit will only be offered to active employees. This is not available for retirees.

2. What is the annual reimbursement amount?

The City of Fort Wayne will provide up to $500 for reimbursement of out of pocket dental and vision expenses for the 2023 plan year. There is no guarantee of this benefit being offered on an annual basis. The City of Fort Wayne will review expenses and determine the amount, if any, that will be offered in subsequent plan years.

3. Do employees have to be covered under the dental and vision plans to be eligible for reimbursement?

Yes, employees and dependents must be enrolled in the dental and vision plans in order to be eligible. If you are only enrolled in one of the plans (dental or vision), claims can only be submitted for expenses incurred under that specific plan.

4. Who owns the HRA?

According to IRS rules, the City of Fort Wayne owns the HRA. However, employees have a 90-day runout period after separation during which reimbursements can be requested for expenses incurred while employed.

5. Who can put money in the HRA?

HRA's are fully owned and funded by the City of Fort Wayne

6. Does the HRA roll over?

No, the HRA does not roll over. However, employees have until March 30th of the following year to submit requests for reimbursement for expenses that incurred the previous year.

7. What is an eligible expense?

Eligible expenses include any out of pocket expenses not covered by the dental and vision plan up to the annual amount allowed for reimbursement under the HRA. All charges must be processed by the plans first to determine out of pocket expenses.

8. How are reimbursements processed?

Requests for reimbursements must be submitted to Automated Group Administration using the HRA reimbursement form. Requests will be processed on the 15th and the last day of the month and must be received two days prior to that to be included. Checks will be mailed to the employee directly to their home address on file.

Benefits & Wellness Department | Laura Helmkamp @ 427.2634 | Katie Adams @ 427-6910

Health Savings Account (HSAs) vs. Flexible Spending Account (FSAs)

HSAs vs. FSAs	Health "Savings" Account HSAs	Flexible "Spending" Account FSAs
Eligibility to Contribute:	You must be on a "high-deductible" health plan that meets IRS definitions. You cannot be covered under any other "traditional" plan including a FSA, unless it is a limited purpose FSA for dental and vision services only.	You can be on a "traditional" health plan.
Account Ownership:	The HSA is a bank account owned by you, regardless of where you work. The money goes with you even if you leave your employer or change plans.	The FSA account is set up and owned by your employer so you lose any money in the account if you leave your employer.
Interest:	Able to earn interest	Does not earn interest
Annual Contribution:	In 2024, the single coverage limit is $4,150 and the family coverage limit is $8,300.	Limit is $3,050
Use it or Lose It:	No. Any unused funds in your HSA at the end of the year, stay in your account indefinitely until you spend them.	There is a 3 month carryover provision that allows you to use dates of service from Jan, Feb & March to clear out the previous year's account. Any unused funds will be forfeited.
Option to Change Contributions:	You can change your election amount when you want as long as it does not exceed the IRS limit.	You can only change your election amount if you have a qualifying event such as marriage, divorce, birth of a child, etc.
Access to Your Money:	You only have access to what has actually been deposited into your HSA to date.	You have access to your entire annual election even if you haven't had all the money deducted from your check yet.
Claims/Approvals:	You are responsible to the IRS for spending only on Qualified Medical Expenses, and you must provide receipts if audited.	Employer approves if your spending meets IRS requirements

Benefits & Wellness Department | Laura Helmkamp @ 427.2634 | Katie Adams @ 427-6910

Health Savings Account (HSA)

Saving and Spending Health Savings Account Dollars

Making the most of your health savings account (HSA) means finding the right balance of saving and spending that works for you and your family right now and when life changes.

Your Account Grows in Three Ways

1. CONTRIBUTIONS

You can contribute to your account in two ways.

- **Payroll deductions.**
- **Direct contributions:** either by an electronic funds transfer from a personal account or by mailing in a personal check along with a contribution form. Friends and family members are also allowed to make contributions to your HSA on your behalf.

  Your employer may provide funding to your account, too. Keep in mind that any contributions your employer makes cannot be deducted on your tax return. Employer contributions are not considered taxable income, so you don't pay taxes on them.

  All contributions—yours, your employer's, friends' or family—count toward the annual maximum set by the IRS.

Contribution Limits

	Individual	Family
2023	$3,850	$7,750
2024	$4,150	$8,300

If you are age 55 or older, you may contribute an additional $1,000.

2. INTEREST AND INVESTMENT EARNINGS

If you hold a balance in your HSA, your account will grow faster to the extent that interest or earnings are credited and remain in the account. Interest can be accrued daily and paid monthly. Any balance above $1,000 can be invested in UMB HSA Saver.®[1] Go to **HSA.UMB.com** for more details on current interest rates and how investment options work.

3. TAX SAVINGS

Your account is completely tax-free,[2] as long as you use your funds to pay for qualified medical expenses.

- **Tax-free deposits.** Whether or not you itemize deductions on your income tax return, your HSA contributions are deductible—up to the IRS annual limit.
- **Tax-free earnings.** Your interest and any investment earnings grow tax-free.
- **Tax-free withdrawals.** The money you withdraw—today or in the future—to pay for eligible medical expenses isn't subject to taxes. That's different from a 401(k) or similar retirement plans, which are taxed when you withdraw funds.

NOTE: *If you use your HSA funds to pay for goods or services that aren't qualified medical expenses, you are responsible for reporting that to the IRS, paying income taxes on the amount and a 20% penalty if you are under age 65.*

INVESTMENTS IN SECURITIES THROUGH UMB HSA SAVER ARE: NOT FDIC-INSURED · MAY LOSE VALUE · NO BANK GUARANTEE

*See reverse side for important disclosure information.

Health Savings Account (HSA)

Spending Your Money

When you have a medical bill, you have a decision to make. Spend your HSA dollars? Or let your balance keep growing? Since your HSA is like a personal banking account, check that you have enough money in your account to cover a bill before you pay it. Don't have enough saved up? Pay your bill out of pocket. Then, if you still want to use your HSA dollars, you can reimburse yourself no matter when you incurred the expense.

Your debit card is sent to you once you open your account. You can request up to four additional cards at no charge. The expenses must be incurred for you, your spouse, or your eligible dependents.

When you are ready to pay a bill, follow these three steps:

1. **Check if it's eligible.** Since your HSA is supposed to work together with your high-deductible plan, qualified eligible expenses for your HSA are typically the same bills that count toward your deductible, plus medicines, certain premiums, and some vision and dental costs. A full list of qualified expenses can be found in IRS Publication 502 at **www.irs.gov**.

2. **Choose a payment method.** Here are some guidelines:

When?	Pay your Bill with:
At the pharmacy. Swipe your debit card like any other credit card when you purchase prescription drugs at a network pharmacy or access your card using your digital wallet. Your pharmacist can typically calculate your cost, including whether or not you've met your deductible, right at the time of your purchase. Also use for vision or dental care.	Debit Card/Digital Wallet (ApplePay, Samsung Pay, Garmin Pay, FitBit Pay)
After you get a bill from a network provider. Wait for your claim to be processed so that you get the network savings and deductible credit applied to your doctor or hospital bill before you pay. Then you can give your HSA debit card number. If your provider won't accept a debit card payment, log into your account on **HSA.UMB.com** to have a check sent directly to your provider. Pay for your long-term care premiums this way, too.	Debit Card or Online Bill Pay
After you've paid in full to see an out-of-network provider. Some providers may require payment at the time of service. And your total bill may vary depending on whether or not you've met your deductible. Once you are logged into your account on **HSA.UMB.com**, follow the instructions to "Request a Reimbursement."	Online Reimbursement

3. **Save your receipts.** The IRS may request that you show proof of how you used your tax-free money. Use UMB's ReceiptVault to store and organize receipts online for qualified healthcare expenses. If you use your HSA funds to pay for goods or services that aren't qualified medical expenses, you are responsible for reporting that to the IRS, paying income taxes on the amount and possibly an additional 20% penalty.

For more information about health savings accounts, see IRS Publication 969, Health Savings Accounts and Other Tax-Favored Health Plans.

INVESTMENTS IN SECURITIES THROUGH UMB HSA SAVER ARE: NOT FDIC-INSURED · MAY LOSE VALUE · NO BANK GUARANTEE

UMB Investment Management selects mutual funds in various asset classes for inclusion in the UMB HSA Saver Investment Program. UMB Investment Management and UMB Custody Services are departments of UMB Bank, n.a. UMB Bank, n.a. is a wholly owned subsidiary of UMB Financial Corporation.

UMB Custody Services provides safekeeping and settlement of the mutual fund investments in the UMB HSA Saver® investment program.

All mention of taxes is made in reference to federal tax law. States can choose to follow the federal tax-treatment guidelines for HSAs or establish their own; some states tax HSA contributions. Please check with each state's tax laws to determine the tax treatment of HSA contributions, or consult your tax advisor. Neither UMB Bank, n.a., nor its parent, subsidiaries, or affiliates are engaged in rendering tax or legal advice and this document is not intended as tax or legal advice.

Funds in an HSA Deposit Account are held at UMB Bank, n.a., Member FDIC.

Health Savings Account (HSA)

Top Questions about Health Savings Accounts

These are answers to some of the most commonly asked questions about health savings accounts (HSAs).

General questions

Q1: WHAT IS A HEALTH SAVINGS ACCOUNT (HSA)?

An HSA helps you set aside money for current and future health care expenses that aren't covered by your medical plan. You can make contributions to your HSA, up to IRS limits. For 2023, the maximum contribution amount from all sources—your contributions, your employer's contributions and any other sources—is $3,850 for individual coverage and $7,750 for family coverage. For 2024, the maximum contribution amount will be $4,150 for individual coverage and $8,300 for family coverage.

Q2: WHAT TYPES OF MEDICAL PLANS ARE COMPATIBLE WITH AN HSA?

To contribute to an HSA, you must be enrolled in a high-deductible health plan (HDHP). An HDHP is a health plan that meets two requirements as specified by the U.S. Treasury Department. First, it must have an annual deductible that meets the minimum deductible amount, which is published annually. Second, the annual out-of-pocket expenses—such as deductibles, copayments and other expenses paid for by the participant—associated with the HDHP may not exceed the specified out-of-pocket maximums. Premiums (the amount you pay each month for coverage) do not count as out-of-pocket expenses.

Q3: HOW DO HSA'S WORK?

You choose how much you'd like to save in your HSA each year and contributions are automatically made from your paycheck to your account. See Question 8 for additional contribution methods. You can choose to pay for current eligible medical expenses with your HSA. Or you can choose to pay for current expenses out of your pocket and save the money in your HSA to pay for future medical expenses. How you use your account and when you use it are entirely up to you.

Q4: IS MY MONEY SAFE IN AN HSA?

Yes. Your HSA deposit account balance is FDIC insured. Once you have $1,000 saved in the HSA, you have the opportunity to open a UMB HSA Saver®[1] investment portfolio to have the option to make investments in securities that carry various levels of risk and reward, similar to investment in a retirement savings plan.

INVESTMENTS IN SECURITIES THROUGH UMB HSA SAVER® ARE NOT FDIC-INSURED · MAY LOSE VALUE · NO BANK GUARANTEE

Q5: WHY SHOULD I CONSIDER ENROLLING IN THE HDHP WITH AN HSA?

If one or more of the following are true for you, you may want to consider making a change to a HDHP with an HSA:

- You are paying for insurance you're not using.
- You want an option to save for current and future medical expenses.
- You want to save on monthly premiums and take more control over how you use your health care benefits.
- You anticipate major health expenses such that you would reach the out-of-pocket maximum associated with the a HDHP.

Eligibility and opening an account

Q6: WHO CAN OPEN AN ACCOUNT?

If you are enrolled in a high-deductible health plan, you are eligible to open an HSA as long as you:

- Are not covered by any other health plan that is not a high-deductible health plan (for example, a spouse's plan),
- Are not enrolled in Medicare benefits, and
- May not be claimed as a dependent on another person's tax return.

Account contributions

Q7: HOW MUCH CAN I CONTRIBUTE?

You can choose how much to contribute to your HSA, up to IRS limits that are set each year. For 2023, the maximum contribution amount from all sources—your contributions, your employer's contributions and any other sources—is $3,850 for employee-only coverage and $7,750 for family coverage. For 2024, the maximum contribution amount will be $4,150 for individual coverage and $8,300 for family coverage.

Q8: HOW DO I CONTRIBUTE TO THE ACCOUNT?

The Welcome Kit you will receive from UMB once you open your account outlines the different ways you can contribute to your account. The simplest way is through pretax payroll contributions, but you may also write a check or transfer money from your bank account to make a lump sum contribution to your HSA. If the money comes from your bank account instead of through payroll contributions, you may deduct the amount you contribute on your taxes[2] since those contributions would be made with after-tax money. Your family members or others can also contribute to the account on your behalf.

Health Savings Account (HSA)

Q9: I'M NEARING RETIREMENT. CAN I MAKE CATCH-UP CONTRIBUTIONS LIKE I DO TO MY RETIREMENT SAVINGS PLAN?

People age 55 and older can make a catch-up contribution each year that is over and above the allowable limit for the individual year. The catch-up contribution is $1,000. You are able to make catch-up contributions until you become Medicare active.

Using your HSA

Q10: WHAT CAN I SPEND MY HSA BALANCE ON?

You can use your balance to pay for qualified medical expenses for you or your covered dependents (shown in IRS Publication 502). Some examples include:

- Your deductible
- Dental treatments, exams or cleaning costs
- Prescription and over-the-counter drug costs
- Vision expenses such as contact lenses or glasses
- Chiropractic or acupuncture fees
- Crutches
- Eye surgery

They don't include insurance premiums other than premiums for long-term care insurance, premiums on a health plan during any period of continuation coverage required by federal law (for example, "COBRA" coverage) or premiums for healthcare coverage while you receive unemployment compensation. You can find a full list of qualified expenses at **www.irs.gov.**

Q11: HOW DO I PAY FOR MEDICAL EXPENSES?

You'll receive a UMB Visa® debit card that you can use to pay for qualified expenses not covered by the high-deductible health plan. Simply swipe the card, or access your card using your digital wallet (includes: Apple Pay, Samsung Pay, Garmin Pay and FitBit Pay) at the pharmacy or for other health-related services and the associated cost will be debited from your HSA balance. Or use your card to pay doctor's visit bills once the claim has been submitted to your insurance carrier so that you will receive the negotiated rates for services. Save your receipts, since you may need them if the IRS requests that you show proof of how you used your tax-free money. Use UMB's ReceiptVault to store and organize receipts online for qualified healthcare expenses. If you cannot use your debit card, you will pay for the expense out of your own pocket, then reimburse yourself from your HSA. If you don't have enough money in your account to pay for the entire amount of an expense (for example, if you just opened the account or the company hasn't made its full contribution yet), you can pay for a portion of that expense with your account and cover the rest with personal funds. Once the HSA funds build and are available in the account, you can reimburse yourself from the HSA.

Q12: HOW DOES MY HSA TRACK WITH MY DEDUCTIBLE?

You may use your HSA to pay for qualified expenses including your deductible. Or you can let the HSA build up for future expenses. The choice is yours. The HSA is not a method to determine if you've met your deductible; that information is available on your medical plan provider's website or on any explanation of benefits (EOBs) that you receive from your plan.

Q13: IF I OPEN AN HSA, CAN I ALSO ENROLL IN A HEALTH CARE FLEXIBLE SPENDING ACCOUNT?

No, you cannot enroll in both. If you are married, you may not have coverage under your spouse's flexible spending account (FSA). You can only have a "limited purpose" FSA. Eligible expenses with a limited purpose FSA include most unreimbursed dental, vision and/or hearing care expenses (including expenses for your dependents), and out-of-pocket medical expenses you paid after you met your plan deductible.

Q14: WHAT ARE THE TAX IMPLICATIONS FOR PARTICIPATING IN AN HSA?

The money you save in your HSA is tax free. The money you contribute isn't taxed, nor is the money taxed as your balance grows. As long as you use the money to pay for qualified expenses, you won't pay taxes when you withdraw it either.

***NOTE**: States can choose to follow the federal tax-treatment guidelines for HSAs or establish their own; some states tax HSA contributions. If you have questions about your tax implications, consult your tax advisor. Withdrawals for non-qualified medical expenses are subject to income taxes and a possible 20% penalty, if you're under age 65.*

Q15: I HAVE AN HSA ALREADY SET UP THROUGH MY FORMER EMPLOYER. CAN I CONTRIBUTE TO THAT HSA INSTEAD WITH PAYROLL CONTRIBUTIONS?

No. However, you may transfer the balance from that HSA into your UMB HSA and continue to make pretax contributions. First, open your UMB HSA. Then decide how you'd like to transfer the funds. You have two options:

1. A direct transfer of all of the balance from one trustee to a UMB HSA.
2. A distribution of funds to the employee, who may then roll over all or part of the HSA balance into a UMB HSA.

Q16: IF I DON'T USE MY BALANCE BY THE END OF THE YEAR, WILL I LOSE IT?

No, the money in your account rolls over from year to year, so you won't lose unused money each year like you would with a flexible spending account (FSA). Best of all, your HSA balance is yours to keep even if you change health plans or changing jobs.

Questions? More details? Visit us online at HSA.UMB.com or call 866.520.4HSA (4472).

This material is provided for informational purposes only and all opinions represent UMB Healthcare Service's judgment as of the date this material was published and is subject to change at any time without notice. You should not use this material as a substitute for your own judgment, and you might want to consult professional advisors before making any tax, legal, financial planning or investment decisions. This material contains no investment recommendations and you should not interpret this material as investment, tax, legal or financial planning advice.

INVESTMENTS IN SECURITIES THROUGH UMB HSA SAVER[1] ARE: NOT FDIC-INSURED · MAY LOSE VALUE · NO BANK GUARANTEE

[1] UMB Investment Management selects mutual funds in various asset classes for inclusion in the UMB HSA Saver Investment Program. UMB Custody Services provides safekeeping and settlement of the mutual fund investments in the UMB HSA Saver Investment Program. UMB Investment Management and UMB Custody Services are departments of UMB Bank, n.a. UMB Bank, n.a. is a wholly owned subsidiary of UMB Financial Corporation.

[2] All mention of taxes is made in reference to federal tax law. States can choose to follow the federal tax-treatment guidelines for HSAs or establish their own; some states tax HSA contributions. Please check with your state's tax laws to determine the tax treatment of HSA contributions, or consult your tax adviser. Withdrawals for non-qualified medical expenses are subject to income taxes and a possible 20% penalty, if you're under age 65.

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Funds in an HSA Deposit Account are held at UMB Bank, n.a., Member FDIC

Health Savings Account (HSA)

EMPLOYER NAME
City of Fort Wayne
ENROLLMENT VERIFICATION NUMBER
THA0001 135359

UMB HSA Online Enrollment Guide

Before you start, make sure you have the following required information available:

- Your physical address (you must have a physical address to open the account, but you may also enter a P.O. Box in "mailing address"), phone number, email address
- Your Date of Birth and Social Security number
- DOB & SS# for your spouse and/or dependents (age 18 or older) if requesting additional debit cards
- Employer verification code and program start date, provided by your employer

Note: You will not choose your beneficiary during enrollment. You will do this the first time you log on to your HSA.

Follow the six-step online enrollment process:

STEP 1: Enrollment Verification Number

Use the unique link provided by your employer, which will take you to Step 2, or go to **HSA.UMB.com** and click on "**Enroll for a new HSA**" and enter Enrollment Verification # provided by your employer.

STEP 2: Eligibility Requirements

Before proceeding, you will be prompted to confirm your eligibility to enroll in an HSA. This confirmation is performed by asking a series of questions. If you answer correctly based on the IRS requirements for eligibility, you will be able to proceed to Step 3.

STEP 3: Account Owner Personal Information

This step contains "sub-screens" that will capture all your personal information, verify your email address (UMB will send a code to your email), and allow you to input additional cardholders, if desired (spouse and/or dependents). **Note**: you must input a physical address to open your HSA or you will get an error message.

STEP 4: Review and Consent to Disclosures

In this step you will be required to open the disclosure documents and consent before you can continue. The documents will open in PDF format.

STEP 5: Verify & Submit Enrollment Information

You will be given a final opportunity to review all the information you typed in before your enrollment is transmitted to UMB for CIP review (Customer Identification Program, as required by Section 326 of the USA PATRIOT ACT, and UMB's CIP policy).

STEP 6: Confirmation

Based on the results during the session, you will get one of the following screens:

Complete Enrollment
The account is created (IF YOU GET THIS SCREEN, NO ADDITIONAL DOCUMENTATION IS REQUIRED).

Incomplete Enrollment
A message will appear indicating that UMB needs additional documentation from you (a copy of your social security card and driver's license) before we can open your account. The message provides three options (request a secure email link, fax or U.S. mail) for sending documentation copies to UMB.
Note: Your account will not be opened during this session. Your account will remain in pending status and unable to accept contributions until UMB receives the requested documentation and opens your account manually.

Once you have completed enrollment, within 5-7 business days you will receive two envelopes in the mail:

1. Your welcome letter with your account number, log on instructions, and additional information about your UMB HSA
2. HSA debit card including additional cards you ordered during your online enrollment session.

Once you receive your welcome letter, you may set up your online access, log in to your account and choose your beneficiary(s).

For questions or more information call 1.866.520.4HSA (4472).

Flexible Spending Accounts (FSA)

Administered by:

The City of Fort Wayne makes available a Health Care Flexible Spending Account and a Limited Purpose Flexible Spending Account administered by Automated Group Administration (AGA).

Flexible Spending Accounts, or FSAs, provide you with an important tax advantage that can help you pay health care and dependent care expenses on a pre-tax basis. By anticipating your family's health care costs for the next plan year, you can lower your taxable income.

Essentially, the Internal Revenue Service (IRS) set up FSAs as a means to provide a tax break. As an employee, you agree to set aside a portion of your pre-tax salary in an account, and that money is deducted from your paycheck over the course of the year. The amount you contribute to the FSA is not subject to social security (FICA), federal, state or local income taxes—effectively adjusting your annual taxable salary. The taxes you pay each paycheck and collectively each plan year can be reduced significantly, depending on your tax bracket. As a result of the personal tax savings you incur, your spendable income will increase.

Flexible Spending Accounts

* **The Health Care Flexible Spending Account** *(not available to those who enroll in a Health Savings Account)*

The health care FSA may be used to pay for **eligible medical, dental and vision expenses** incurred for yourself, your spouse, and your eligible dependents subject to the maximum for the plan year.

* **The Limited Purpose Flexible Spending Account** *(available to those who enroll in a Health Savings Account)*

The Limited Purpose FSA may be used to pay for **eligible dental and vision expenses** incurred for yourself, your spouse, and your eligible dependents subject to the maximum for the plan year.

Health FSAs employ a "use-it-or-lose-it" model. If you do not use the funds that you contribute to your FSA within the end of the plan year, you will have to forfeit those funds.

For information about eligible medical expenses, please refer to IRS Publication 502, Medical and Dental Expenses, available at www.irs.gov/publications/p502/index.html. Please note: over-the-counter drugs used to be eligible expenses, but a law effective Jan. 1, 2011, only allows claims for over-the-counter medication or drug expenses (other than insulin) to be reimbursed **if the patient has a prescription**. This new rule does not apply to items for medical care that are not considered medication or drugs. Equipment such as crutches, supplies such as bandages and diagnostic devices such as blood sugar test kits still qualify for reimbursement without a prescription.

* **The Dependent Care FSA—Administered by the City of Fort Wayne**

The Dependent Care FSA lets you use pre-tax dollars toward qualified dependent care. The annual maximum amount you may contribute is $5,000. In order for dependent care services to be eligible, they must be for the care of a tax-dependent child under age 13 who lives with you, or a tax-dependent parent, spouse or child who lives with you and is incapable of caring for himself or herself. The care must be needed so that you and your spouse (if applicable) can go to work. Care must be given during normal working hours (instances such as Saturday night babysitting does not qualify) and cannot be provided by another of your dependents.

If you elect to contribute to the dependent care FSA, you may be reimbursed for:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

Is the FSA program right for me?
The flexible spending accounts offered are beneficial for anyone who has out-of-pocket medical, dental, vision, hearing or dependent care expenses beyond what his or her insurance plan covers.

It's easy to determine if an FSA will save you money. At enrollment time, you will need to determine your annual election amount. Estimate the expenses that you know will occur during the year. These include out-of-pocket expenses for yourself and anyone claimed as a dependent on your taxes. If you had $100 or more in recurring or predictable expenses, the accounts can help you stretch your dollars.

How do the accounts work?
If you decide to enroll in one or both of the accounts, your contributions are taken out of each paycheck—before taxes—in equal installments throughout the plan year. These dollars are then placed into your FSA. When you have an eligible health care or dependent care expense, you must submit a claim form along with an itemized receipt to be reimbursed from your account. If you are provided with a Flex Debit Card, the card gives you instant access to your Health Care or Limited Purpose account. The card can be used at qualified providers that accept the card. Instead of paying out-of-pocket expenses and waiting for reimbursement, the Flex Debit Card pays the provider automatically from the account.

The Health Care/Limited Purpose FSA's will reimburse you for the full amount of your annual election (less any reimbursement already received), at any time during the plan year, **regardless of the amount actually in your account**. The Dependent Care FSA will only reimburse you for the amount that is in your account at the time you make a claim.

Flexible Spending Accounts (FSA)

What is a Grace Period?

A Cafeteria Plan may include a grace period of up to the fifteenth day of the third month immediately following the end of each plan year. In other words, employers may add up to a 2 1/2 month grace period to the end of their Section 125 plan year. A grace period extends the amount of time in which participants may incur eligible medical expenses for a period of time after the plan year ends.

Maximum Annual Contributions

	2024
Health Care FSA	TBD (2023 - $3,050)
Limited Purpose FSA	TBD (2023 - $3,050)
Dependent Care FSA	$5,000

Important Rules for FSA's

- You cannot change your election during the year unless you experience a qualifying life event.
- Only expenses for services received in the plan year and while you are covered under the FSA can be reimburses by the contributions you make for the year.
- You Lose What You Don't Use! (as required by the IRS)

Plan Specifications

Plan Year: January 1 - December 31

Incurred Period: Expenses must be incurred during the plan year or before the end of the grace period. For your plan, it must be incurred between January 1st and March 15th of the following year. For example: For the 2024 Plan Year the expenses must be incurred between January 1, 2024 and March 15, 2025.

Reimbursement Requests Deadline: Reimbursement requests must be submitted by March 31 of the year following the end of the Plan Year. For example: For the 2024 Plan Year the expenses must be submitted no later than 90 days (March 31) following the end of the plan year.

Requirements to become eligible to participate in the Plan: The eligibility requirements are the same as the Employer's group health plan. Employee doesn't have to actually participate in the health plan, only meet the eligibility requirements.

Flexible Spending Accounts (FSAs)

Flexible Spending Account Debit Card Information

- Your debit card does not need to be activated. It will automatically be activated when you use it. Be sure to sign your card.
- Your debit card should be accepted anywhere the Master Card is accepted, but can only be used for eligible expenses. Ineligible expenses should be declined.
- SAVE YOUR RECEIPTS!!! You may be asked to furnish documentation subsequent to using your card. Save your receipts a minimum of 120 days.

Flexible Spending Account Website

There is a website you can go to for checking your card balance or for looking at recent transactions. Below are instructions for signing onto the website your first time:

- Go to website: website address is www.wealthcareadmin.com
- Click on Participant Login (use name of person working for the employer sponsoring the plan)
- Click on Create Account
- Enter requested information. **Your employee id number is your social security number. The employer id is AGA6650. You will also need your flex card number.**
- You will create your own user name and password to use to sign into the system. The user name cannot be longer than 16 characters. The password must be at least 6 characters and contain at least one number and one letter. No special characters are allowed. Passwords are case sensitive.

AGA Web Portal

QicLink Benefit Exchange (QBE)

QicLink Benefit Exchange (QBE) provides internet access to claim information for members. As a QBE member, you will have access to the following features:

- View member information
- View deductible and out-of-pocket information
- Submit request for ID cards
- View or print copies of explanations of benefits (EOB's)
- Access links to healthcare management-related websites

You will need to register first to use QBE. Visit:
https://b23qbeprod.cishoc.com/B23AGA/Login.aspx?CID=00061005&DID=AGA
Click on New Member Registration
Then enter your group number (6650), your Member ID from your insurance card and your date of birth. QBE can also be accessed through the www.aga-tpa.com website.

NOTE: User id, password and the answer to your security question are case sensitive. When logging in, you must type your user id and password exactly as entered here. If member self registration is successful, a confirmation message will appear. Click okay to continue to the log in window.

Now you're ready to use QBE. Type the user name and password you chose and click on Login. Click on Accept.

Use any of the menu options to view information:

- Home
  - Logon Statistics
- Benefits Information
  - Member Information tab
  - Deductible Tab
  - Out-of-Pocket tab
- Claims
  - By Enrollee/Member
  - By Claim Number
  - By Check Number
- Member Request
  - Request for ID Cards
  - Employer/Plan Sponsor
  - Protected Health Info Restriction
- My Accounts
  - Flexible Spending
  - Health Reimbursement Arrangements

Flex Card Website

Signing on to Flex Card website for the first time

Go to website: website address is www.wealthcareadmin.com
Click on Participant Login (use name of person working for the employer sponsoring the plan)
Click on Create Account
Enter requested information. Your employee id number is your social security number (no dashes). The employer id is AGA6650 or you can enter the flex card number, don't enter both.
You will create your own user name and password to use to sign into the system. The user name cannot be longer than 16 characters and no special characters.

- Password must contain between 8 and 16 characters.
- Password must contain one instance of at least three of four types of characters: upper case, lower case, special character, and number.
- Password cannot contain the same character repeating 3 or more times, for example, "AAA" is invalid.
- Password cannot contain the word "password".
- Password cannot be the same as a username.
- Password cannot contain spaces.

ALL ENTRIES ARE CASE SENSITIVE!

Wellness Benefits

CITY OF FORT WAYNE HUMAN RESOURCES

All employees enrolled in the City's Health Plan receive an annual WELLNESS BENEFIT to make it easier to choose a healthy lifestyle!

Annual Wellness Benefits

$2000 ROUTINE SCREENING & TESTS

Co-pay (physicians charge only)
$30 $1200 deductible plan
$0 $3400 deductible plan

Each enrolled member receives an annual $2000 wellness benefit! This applies to both the employee and their spouse, provided they are enrolled in the City's Health Plan.
Covered Expenses include: Routine physical examinations, preventive immunizations, flu shots (if done at the doctor's office), routine prostate examinations, routine PAP tests, routine mammograms, and all other types of wellness screenings (EBT scan, bone density, etc.)

(These charges do not track towards your $2000 annual limit. They are paid at 100%.)

Flu shots, Shingles shots and Pneumonia shots can now be obtained through the pharmacy and paid at 100%.

Colonoscopies will be paid at 100% once every 10 years for individuals 45 or older. For higher risk individuals, colonoscopies will be covered at 100% once every 5 years beginning at the age of 40.

$400 HEALTHY LIFESTYLE BENEFIT

Each enrolled member also receives an additional $400 benefit for exercise, weight loss programs, physical trainer expenses, and registration fees for certified walk/runs! Employees and enrolled spouses benefits can be combined and used toward family/group memberships.

100% PAID TOBACCO CESSATION

100% coverage available for treatments including counseling, acupuncture, hypnotism, etc.

Prescription medications for the purpose of tobacco cessation now filled with a $0 copay. Over the counter tobacco cessation products including patches, gum and nasal sprays can be purchased at the pharmacy - 30 day supply, $0 copay. Some limitations apply.

Annual Health Screening

We conduct an annual Health Screening for employees, spouses & retirees. By participating you will receive a **10% CREDIT** off your health insurance deductible for the following year! Components of the screening include:

Chem-30, Complete Blood Count, A1C, Thyroid and PSA testing
Height/Weight
Blood pressure

ALL INFORMATION IS CONFIDENTIAL
Results are mailed directly to you. It's up to you to forward your results to your doctor.

BENEFITS & WELLNESS DEPARTMENT | Laura Helmkamp @ 427.2634 I Katie Adams @ 427-6910

Wellness Benefits

GUIDELINES FOR HEALTHY LIFESTYLE BENEFIT REIMBURSEMENTS

GYM CLUB REIMBURSEMENTS OR ANY OTHER EXERCISE RELATED MEMBERSHIP THAT HAS A MONTHLY OR ANNUAL FEE (Gyms, Yoga/exercise studios, Tennis/Racquet Ball Facilities, etc.)	• $400 benefit is divided into a monthly maximum benefit of $33.33 per employee and/or spouse (if on health plan). If the membership costs less than $33.33 per month reimbursement will only be up to the cost of the membership. • Must attend at least two (2) times per month to receive monthly benefit. Use the Gym Club Reimbursement Form that is available at www.cityoffortwayne.org/city-benefits to submit proof of attendance. • First reimbursement submission each year must provide proof of the cost of the membership. This can be in the form of a signed contract or a copy of your pay stub if payroll deducted.
EXERCISE CLASSES/YOGA/PERSONAL TRAINERS THAT DO NOT HAVE A MONTHLY OR ANNUAL FEE (Pay per session or block of sessions)	• Will not reimburse for sessions unless you provide proof that class was attended. To submit proof of attendance use the form available at www.cityoffortwayne.org/city-benefits. • Submission must include proof of cost and payment. • Will pro-rate reimbursement if not all sessions are used in a block purchase. • Online exercise or training programs/Apps are eligible for reimbursement but home exercise equipment such as a treadmill or bicycle is not.
CERTIFIED RUN/WALKS/CYCLING EVENTS	• Reimbursement for these events will only be after the event and proof of cost and participation is submitted. • Fees for recreational leagues such as baseball, bowling, etc. or memberships for country clubs or neighborhood pools are not eligible for reimbursement.
WEIGHT LOSS PROGRAMS	• Monthly or annual fees will be pro-rated by number of sessions per month or year and only those sessions attended will be eligible for reimbursement. To submit proof of attendance use the form available at www.cityoffortwayne.org/city-benefits. • Online weight loss programs/Apps are eligible for reimbursement. • Food, medication and/or supplements are not eligible for reimbursement.

All reimbursements are considered taxable income and will be reimbursed on your paycheck once per month, including any reimbursement for a spouse. All submissions must be received by Automated Group Administration no later than the 20th of each month to be eligible for reimbursement the following month. You can submit claims monthly, quarterly or annually if you choose as long as the proper documentation for attendance is attached to the submission. If you have any questions, please contact the Benefits Department at 427-6910 or 427-2634.

BENEFITS & WELLNESS DEPARTMENT | Laura Helmkamp@ 427.2634 I Katie Adams @ 427-6910

Employee Assistance Program (EAP)

EMPLOYEE ASSISTANCE PROGRAM FAQ

No one is immune to hardship. That is why your employer is providing the Parkview Employee Assistance Program (EAP) for you and your family at no cost. This confidential service can be of great value as you work through life's storms. Below are frequently asked questions that will help guide you in understanding EAP.

What is an employee assistance program?

Parkview's EAP offers you, as well as those living in your household, short-term counseling services. Counseling sessions last between 45-50 minutes, are confidential, and are free of charge to you as an employee of your company. Your human resources department or manager can advise you as to the number of sessions provided by your company.

Will my co-workers, manager, or anyone else find out I came to see you?

Parkview's EAP services are confidential and no information about you, your participation in our program, or what you and your counselor talk about will be released to anyone without your written consent.
Please note: like any other counseling service you might receive, your counselor is legally required to report if you are intending to harm yourself, someone else, or in cases of child abuse or elder abuse.

What happens if I want to continue counseling after my sessions run out for the year?

The goal of EAP services is to help address your struggles, concerns, and stressors before they get to the point of needing long-term counseling. However, we understand that there will be situations when long-term counseling is needed. In these cases, your counselor will work with you to find options for an outpatient counselor within your insurance network who may be of assistance to you.

What if I am in a joint custody situation with my child and I want him/her to get counseling?

In cases regarding joint custody, we ask that both parents sign consent for the child to receive counseling services from Parkview EAP prior to the child being seen.

Can my family members receive counseling from Parkview's EAP?

Anyone living in your household, included spouses and children, are eligible to receive the same number of counseling sessions as you. For instance, if you receive four counseling sessions, your spouse receives four sessions as well.

How do I get started?

Give us a call at 260-266-8060 or 800-271-8809 to schedule an appointment with one of our counselors. Any family member who is seeking counseling who is 18 or older will need to call to make the appointment themselves.

To learn more about Parkview Employee Assistance Program and our counselors, visit Parkview.com/EmployerSolutions

Employee Assistance Program (EAP)

Parkview Employee Assistance Program

HELPING YOU WEATHER LIFE'S STORMS.

When facing life's storms, it's comforting to know that you have somewhere to turn.

An important resource

No one is immune to hardship. That is why your employer is providing the Parkview Employee Assistance Program (EAP) for you and your family at no cost. This confidential service can be of great value as you work through life's storms.

Private and professional

All of our EAP services are kept confidential. In fact, no information about you or your participation in the program is released without your written consent. Your participation in the EAP program will not be shared with your supervisor.

(continued)

MKTG-32503 (09/2021)

Convenient locations

Visit **Parkview.com/EmployerSolutions** for our most up-to-date list of locations.

Parkview Employee Assistance Program offering Zoom consultations

EAP provides consultations via your mobile device or a computer with a camera in the state of Indiana.

Employee Assistance Program (EAP)

Help in any situation

The Parkview Employee Assistance Program can help you and your family with a variety of difficult situations. The EAP counselors are knowledgeable in a variety of areas, including:

- Crisis intervention
- Trauma responses
- Family and relationship difficulties
- Alcohol and drug dependence
- Personal and work stress
- Divorce difficulties
- Troubled teenagers
- Emotional difficulties

Parkview EAP has an in-house financial counselor who can assist individuals with financial issues that are impacting their daily lives.

Often, the best approach includes short-term counseling sessions with an EAP professional. There may be times when a referral to another professional or agency better suited to address the situation is required.

Examples include:

- Support groups
- Outpatient counseling

Should the need arise, your insurance benefits and coverage would be considered.

Simple

When you or your family member calls for an appointment with an EAP counselor, your appointment will be scheduled as promptly as possible.

At the appointment, you will meet with a trained professional who will help assess your situation. He or she will assist you in determining the steps necessary for resolving the issue.

Your confidential EAP services are provided by your employer at no cost to you.

Flexible

The Parkview Employee Assistance Program counselors will make every effort to find an appointment that fits easily into your schedule. Confidential appointments can be made by you or any member of your family living in your home. Appointments for children under the age of 18 must be scheduled by a parent or guardian. Anyone over the age of 18 must schedule their own appointment.

Call Parkview Employee Assistance Program today. Together, we will ride out life's storms.

260-266-8060 • 800-721-8809

Employee Assistance Program (EAP)

YOUR MENTAL HEALTH MATTERS

The City of Fort Wayne understands the importance of mental health in your personal and professional life. As a thank you for your hard work and dedication, the City is enhancing your benefits package and increasing the number of counseling sessions available through the Parkview Employee Assistance Program. Effective June 1, 2023, you will have eight (8) sessions available per year.

Employee Assistance Program

Employee Assistance Program (EAP) counseling services are available to all City of Fort Wayne employees and those living in their household. All services are free for you to use and sessions are confidential and provided by a licensed Parkview counselor in a welcoming and comfortable setting. No information regarding participation in services is released to your employer without written consent from the patient.

Individuals and couples can meet with a counselor to discuss a variety of concerns, including (but not limited to):

- Crisis intervention
- Grief and loss
- Family and marital stress
- Relationship issues
- Alcohol and substance abuse
- Personal and work stress
- Divorce recovery
- Parent coaching
- Emotional difficulties
- Financial challenges

You are provided with eight (8) counseling sessions per person per calendar year for yourself and those living in your home.

If you or someone you know is currently experiencing thoughts of suicide, or a mental health or substance use crisis, please call **988** to reach the Suicide & Crisis LIfeine and speak with a trained crisis specialist 24/7.

Scan the QR code with your mobile phone camera for more information on Parkview EAP services and for a list of office locations.

Schedule an appointment with Parkview EAP: **260-266-8060** or **800-721-8809**

In-person and virtual appointment options are available.

457 Retirement Plan

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What is a 457 retirement plan?

The 457 is a tax-deferred retirement plan designed to help you invest regularly for your retirement. It is offered to you through your employer and is available only to public employees and certain employees of many tax-exempt organizations. Your contributions are taken directly from your salary before it is taxed, and each plan offers you a selection of investment options.

457 basics and benefits

Why should I consider a 457 plan?

There are several benefits to consider when joining a 457 plan.

- **Your retirement**—A 457 plan is an easy way to invest for your retirement.
- **It's easy**—You contribute through the convenience of automatic payroll deduction.
- **Tax-deferred growth**—Your money grows on a tax-deferred basis.
- **Consistent savings**—Saving a set amount on a regular basis, such as every payday, can help increase your earnings.
- **Reduced taxable income**—Your gross taxable income will be reduced by the contributions you make.

Not a deposit	Not FDIC-insured	May go down in value
Not insured by any federal government agency	Not guaranteed by any bank or savings association	

2

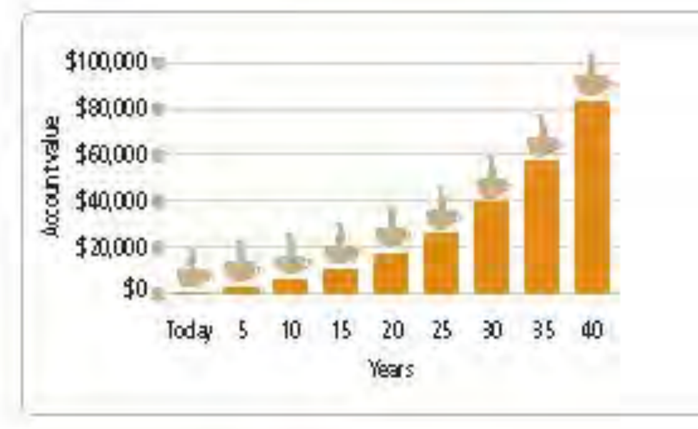
457 Retirement Plan

Once you've committed to saving regularly with your 457 plan, getting money into your account is easy.

Begin today

Think you can't afford to start a retirement plan today? It might be easier than you believe. If you were to commit just $10 a week—what you might spend on coffee each week—to your 457 plan, even small contributions can add up over time.

Assumes a $10/week contribution and a 6% annual return in a tax-deferred account. This hypothetical example is not indicative of any product or performance and does not reflect any expense associated with investing. Taxes will be due upon distribution. It is possible to lose money investing in securities.



How do I make contributions?

It's simple. Your contributions are made through payroll deduction. To participate in a 457 retirement plan, you must first satisfy the eligibility requirements and complete the Participation Agreement. The amount you designate as a deduction will be automatically withdrawn from your paycheck and contributed to your 457 retirement plan. Be sure to check with your employer or Lincoln representative for your specific plan enrollment requirements.

Can I change the amount or stop my contributions?

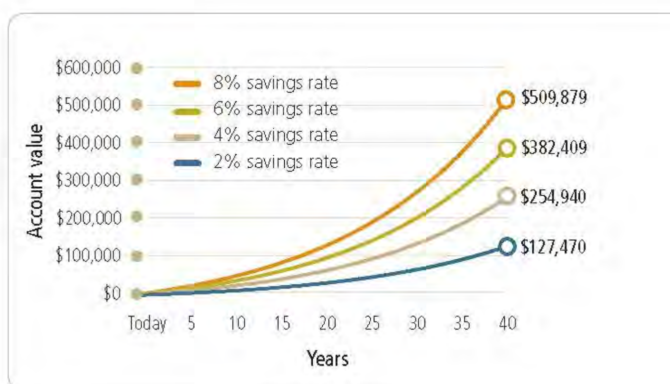
Yes. You may raise or lower the amount of your contributions during any open enrollment period (or as permitted by your employer). You also may stop making contributions into the plan by submitting a written request to your employer.

If you discontinue your contributions, there is no penalty to you, and you are entitled to receive all of the money you've contributed to the plan and its earnings when you retire or meet the other withdrawal conditions. If you want to start making contributions again, you may do so during any open enrollment period.

How much should I contribute?

Deciding how much to contribute to your plan depends on many factors, including what you can afford and how long you have until retirement. Even a small amount, invested regularly, can add up to significant savings over the long term.

457 Retirement Plan



This graph assumes a $40,000 annual salary and a 6% annual return in a tax-deferred account. This hypothetical example is not indicative of any product or performance, and does not reflect any expense associated with investing. Taxes will be due upon distribution. It is possible to lose money investing in securities. Changes in tax rates and tax treatment of investment earnings may impact the comparative results. You should consider your personal investment horizon and income tax bracket, both current and anticipated, when making an investment decision, as these may further impact the results of the comparison.

Are there limits to the amount I can contribute?

Yes. The tax law limits the maximum amount of contributions that can be excluded from your salary in any one year.

How much can I contribute if I join the plan midyear?

You can make up for any missed months, as long as your total contribution does not exceed the annual limits.

What investment choices do I have for my 457 plan contributions?

There are a variety of investment options available for, and specific to, your 457 plan. Contact your employer or Lincoln representative for the list of your choices.

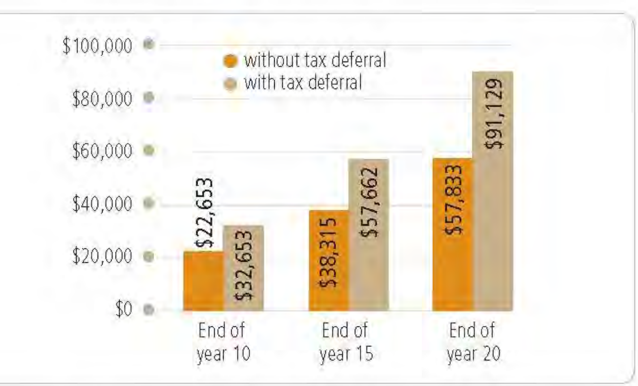
Does 457 participation affect my Social Security benefits?

No. You can still contribute to other retirement plans (contribution limits may apply), and your Social Security taxes and benefits are not affected by 457 participation.

What do I need to know about taxes and my 457 contributions?

The consistent and convenient contributions to a 457 plan are just some of the benefits. You also should be aware of the tax benefits of investing in a 457:

- **Tax deferral**
  Any contributions made to your plan will be allowed to grow tax-deferred. This means you do not pay taxes on that money until it is withdrawn. Tax deferral allows your money to accumulate faster than taxable investments.



This is a hypothetical example. It is not indicative of any product or performance and does not reflect any expense associated with investing. It assumes $200 monthly contributions, 6% interest, and a 25% tax bracket. Taxes will be due upon distribution of the tax-deferred amount, and if shown, results would be lower. Actual investment results will fluctuate with market conditions, so that the amount withdrawn may be worth more or less than the original amount invested.

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457 Retirement Plan

- **Reduce your taxable income**
  Your 457 contributions are deducted from your salary before taxes. Much like taking a deduction on your income taxes, this reduces your taxable income and the amount of tax due on that income.

  Keep in mind that when any money is distributed or withdrawn from the plan, it is taxed as ordinary income. If that happens during your retirement, you may be in a lower tax bracket at that time and may pay less tax on the money withdrawn.

How long can I contribute to my 457 plan?

You can contribute to your 457 plan as long as you are an employee with an eligible employer, and the employer permits salary reduction contributions.

Is the money that I put into the 457 plan subject to my employer's creditors?

No, it isn't. 457 deferred compensation plans are held for the exclusive benefit of the participants and their beneficiaries. This ensures that your contributions into the plan will be there when you need them.

NOTE: This does not apply to tax-exempt organizations.

Your 457 deferred compensation is designed as a long-term retirement plan. When you reach retirement, and in some cases prior to that, you may need access to your money.

How can I access funds from my account?

There are two ways to receive money from your 457 plan:

- Prior to retirement, you may take a withdrawal, subject to certain restrictions.
- Upon your retirement, you can begin taking distributions.

When can I take a withdrawal from my 457 account?

Withdrawals are available from your 457 plan for specific reasons, such as:

- retirement
- separation from service with your employer
- total and permanent disability
- unforeseeable emergency
- distributions made to your beneficiaries upon your death
- qualified domestic relations order (divorce payments to ex-spouse or children)

Important considerations: If you take a withdrawal for one of these reasons, you will have to pay income taxes unless the distribution is rolled to an IRA or another qualifying plan. In addition, the account may have withdrawal or surrender charges. Some plans may have additional withdrawal limitations.

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457 Retirement Plan

Once I retire, when am I required to take retirement distributions and for how long?

The IRS requires that you begin to receive distributions no later than April 1 following the year you reach age 70½ (unless you are still working for and do not own more than 5% of the organization). Once you begin receiving required distributions, you must continue to receive them until your account value is depleted or until your death.

How will I receive my retirement distributions?

Your retirement distributions may be paid out in a number of ways, such as:

- automatic withdrawal
- annuity payout options
- lump sum withdrawal

What if I change jobs?

If you change employers, you have several options:

- In some cases, you may continue making 457 contributions to your previous employer's plan.
- You may leave your accumulated assets in your previous employer's plan, but you must direct future contributions to a retirement plan sponsored or administered by your new employer.
- You may be able to roll over assets from your present contract/program to the options offered by your new employer, or to any other qualified funding vehicle, such as an IRA. No taxes will be due if the rollover is executed properly.
- You can take a lump sum distribution. Remember, distributions are subject to a 20% federal withholding and taxed as income for that year.

What happens to my 457 account if I die?

If you die before your retirement distributions have begun and your beneficiary is your spouse, he/she may elect any distribution method that was available to you, such as:

- Rolling the money over to an IRA
- Leaving the accumulated assets in the contract/program
- Taking distributions over his/her life expectancy

If your beneficiary is not a spouse, he/she has two options:

- Electing to receive a lump sum distribution, payable within five years of your death
- Electing, within one year of your death, to receive periodic payments based upon that beneficiary's life expectancy

If you die after you've begun to receive distributions based upon your lifetime, your beneficiary can receive payments over his/her remaining life. The beneficiary also may choose to take the entire remaining account balance at any time during the payout period.

May I take out a loan?

Yes. Loans are available from 457 retirement plans. Check with your employer or Lincoln representative to see whether loans are permissible with your plan.

Contact your employer or Lincoln representative for more information.

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457 Retirement Plan

Tomorrow's plan begins today

Once you understand the basics, investing in a 457 is an easy, convenient way to begin securing your future. Automatic salary reductions alleviate the worry of making regular contributions on your own, and tax-deferred growth allows you to focus on building your financial future.

Take advantage of the opportunity today. Waiting, even as little as one year, can cost your retirement thousands of dollars.

Age	Retirement plan balance at age 65	Cost of waiting one year
25	$383,393	**$24,039**
26	$359,354	
35	$195,851	**$13,423**
36	$182,428	
45	$91,129	**$7,495**
46	$83,634	

This is a hypothetical illustration and is not indicative of any product or performance; it does not reflect any taxes due upon distribution or any fees associated with investing. Investment options are subject to market risk. It assumes $200 monthly contributions, 6% interest, and retirement at age 65.

More than eight out of 10 Americans take advantage of the retirement plan offered to them.[1] Join them, and begin working toward your future today.

If you have additional questions about your employer's 457 plan, please contact your employer or Lincoln representative.

The *Lincoln InStep*® participant retirement program provides one-on-one guidance and education for retirement planning assistance —as well as seminars, print material, and Internet tools—all geared to unique learning styles and changing needs over time. You also can meet with a retirement professional for personal help—compliments of your employer.

[1] Employee Benefit Research Institute, "The 2010 Retirement Survey: Confidence Stabilizing, but Preparations Continue to Erode," March 2010: 18.

11

Mutual funds and variable annuities are sold by prospectus. Investors are advised to carefully consider the investment objectives, risks, and charges and expenses of a mutual fund, and in the case of a variable annuity, the variable contract and its underlying investment options. To obtain a mutual fund or variable annuity prospectus that contains this and other information call: 800 4LINCOLN. Read the prospectus carefully before investing or sending money.

Variable annuities are long-term investment products designed particularly for retirement purposes and are subject to market fluctuation, investment risk and possible loss of principal. Variable annuities contain both investment and insurance components and have fees and charges, including mortality and expense, administrative and advisory fees. Optional features are available for an additional charge. The annuity's value fluctuates with the market value of the underlying investment options, and all assets accumulate tax-deferred. Withdrawals of earnings are taxable as ordinary income and, if taken prior to age 59½, may be subject to a 10% federal tax penalty. Withdrawals will reduce the death benefit and cash surrender value. There is no additional tax-deferral benefit for an annuity contract purchased in an IRA or other tax-qualified plan.

Variable annuities sold in New York are issued by Lincoln Life & Annuity Company of New York, Syracuse, NY, and distributed by Lincoln Financial Distributors, Inc., a broker/dealer. For all other states, variable annuities are issued by The Lincoln National Life Insurance Company, Fort Wayne, IN, and distributed by Lincoln Financial Distributors, Inc., a broker/dealer. **The Lincoln National Life Insurance Company does not solicit business in the state of New York, nor is it authorized to do so. Contractual obligations are backed by the claims-paying ability of the appropriate issuing company.**

The mutual fund-based programs include certain services provided by Lincoln Financial Advisors Corp. (LFA), a broker/dealer (member FINRA) and an affiliate of Lincoln Financial Group, 1300 S. Clinton St., Fort Wayne, IN 46802. Unaffiliated broker/dealers also may provide services to customers.

Not a deposit	Not FDIC-insured	May go down in value
Not insured by any federal government agency	Not guaranteed by any bank or savings association	

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Hello future.®

Lincoln Financial Group℠

www.LincolnFinancial.com
Log in: Employer Retirement Plans

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

Affiliates are separately responsible for their own financial and contractual obligations.

LCN1105-2054602
ECG 5/11 **Z03**
Order code: DC-457-BRC001

457 Retirement Plan

[1] "Taking the mystery out of retirement planning," Department of Labor (November 2020).
[2] "How much should public employees save for retirement," National Public Pension Coalition (December 2016). The percentage is based on an average individual qualifying for full public pension benefits.
[3] "Retirement," USA.gov (January 2020). The percentage is based on an average individual qualifying for full Social Security retirement benefits.
[4] "Public pension eligibility," Ballotpedia (accessed Oct. 11, 2021).
[5] "Retirement Planning Needs of Private- and Public-Sector Employees More Similar Than Different," PlanSponsor (Oct. 27, 2020).

This material is not a recommendation to buy or sell a financial product or to adopt an investment strategy. Investors should discuss their specific situation with their financial professional.

Investing involves market risk, including possible loss of principal. No investment strategy or program can guarantee to make a profit or avoid loss. Actual results will vary depending on your investment and market experience.

Retirement products are offered by Nationwide Trust Company, FSB, or Nationwide Life Insurance Company.

Nationwide Retirement Specialists are Registered Representatives of Nationwide Investment Services Corporation (NISC), member FINRA, Columbus, Ohio.

Nationwide, the Nationwide N and Eagle, Nationwide is on your side and My Investment Planner are service marks of Nationwide Mutual Insurance Company. My Interactive Retirement Planner is a service mark of Nationwide Life Insurance Company. © 2021 Nationwide
NRM-19251M1.1 (11/21)

Take control of your financial future today

Why join the retirement plan?

If you plan to rely solely on your pension and Social Security benefits for income, you could face a potential gap in your budget.

Your income gap could be up to 20% at retirement. Here's why:

80% to 90%
Amount of your income at retirement that experts say you may need to maintain your standard of living in retirement[1]

70%
Amount of income at retirement that your pension and Social Security benefits (if any) may provide[2,3]

59
Age at which most public employees retire[4]; first responders tend to retire around age 55, well before the age to qualify for Social Security benefits[5]

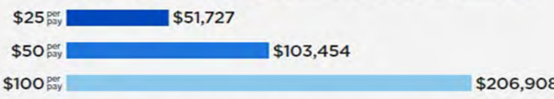
Potentially making that gap even larger are other factors such as:

- Out-of-pocket medical costs
- Inflation
- Not qualifying for full benefits
- Outliving your resources
- Needing long-term care
- Planning for major trips and other activities

Your deferred compensation plan was built for this.

When you join the plan, you can begin to fill the potential gap between the retirement benefits you can expect and the income you might need.

You could grow quite a gap filler after 25 years of investing through your retirement plan.



This hypothetical illustration shows how much various deferral amounts per biweekly paycheck for 25 years could accumulate, given an 8% annual rate of return for an investor. This example is not a yield projection for any specific investment. If fees, taxes and expenses were reflected, the return would be less.

Why join now?

The secret ingredient of long-term savings is time.

The more time you give your savings to potentially grow, the easier it is to contribute enough per pay period to potentially meet your future needs.

How much should you save?

While this decision is unique to each employee, we offer two online tools that can help you decide:

Paycheck Impact Calculator
See how your take-home pay would be affected by various contribution amounts.

My Interactive Retirement Planner℠

Test several scenarios to discover how different contribution amounts could grow over time.

How do you want to handle investment decisions?

Option 1: Do it myself
Investigate the Plan's investment options and fees and then pick the right mix for your investment strategy.

Option 2: Help me do it
Use **My Investment Planner℠** to find options that might fit your investing style and tolerance for risk.

We make getting started easy!

Gather these three items:

1. **Social Security number**
2. **Employer name**
3. **Annual salary**

For personal assistance, contact your Nationwide® Retirement Specialist.

Patrick Burkhart
260.385.6336
burkhp3@nationwide.com

Public Employees' Retirement Fund

7/1/2021

PERF AT A GLANCE

PUBLIC EMPLOYEES' RETIREMENT FUND
HYBRID PLAN

	Defined Benefit	Defined Contribution (DC) Account
Vesting	10 years of PERF and/or TRF-covered service 8 years for specified elected positions	Immediate
Contributions	**Employer pays 100 percent** ■ No member contributions ■ Employer contribution rate determined annually by INPRS board	**Mandatory 3 percent of gross wages paid by:** ■ Employer, or ■ Employee, or ■ Shared by employee and employer **Voluntary Contributions*** ■ Employee can elect to contribute additional monies ■ Employee's voluntary contributions are post-tax
Eligibility for Retirement Benefit Payment	■ Age 65 with 10 years of service ■ Age 60 with 15 years of service ■ At age 55 if age and creditable service total at least 85 ("Rule of 85") ■ Early retirement with reduced benefits between ages 50-59 with 15 years of service ■ Age 70 with 20 years of service** ■ Special provisions for certain elected officials	Automatic eligibility for withdrawal once you separate from service*** *Members separated from service may retire with PERF and continue to work in a non-INPRS covered position, as long as they meet age and service requirements.*
Eligibility for Disability Benefit Payment	■ Qualified for Social Security disability benefits and furnished proof of qualification ■ Received a salary from a PERF-covered position within 30 days of termination date ■ Minimum of five years of service	Automatic eligibility for withdrawal if receiving a disability benefit
Investment Options	Members do not direct the investment of the Defined Benefit.	Choice of eight funds: ■ Stable Value Fund ■ Money Market Fund ■ Fixed Income Fund ■ Inflation-Linked Fixed Income Fund ■ Large Cap Equity Index Fund ■ Small/Mid Cap Equity Fund ■ International Equity Fund ■ Target Date Funds
Account Statements	You receive PERF Annual Member Statements (AMS) by mail. The AMS includes your estimated annual defined benefit amount, years of service, and DC account investment information. You can choose to have your AMS emailed to you every year. Copies are also available at myINPRSretirement.org from your account profile.	Quarterly statements are provided online and/or mailed by PERF.

* Go to bit.ly/perfhybridcontributions for more on voluntary contributions.
**Actively employed members who have completed at least 20 years of service may apply for retirement benefits at age 70, remain actively employed and receive monthly benefits.
*** Certain restrictions may apply if you are vested in a pension benefit.

Public Employees' Retirement Fund

7/1/2021

	Defined Benefit	Defined Contribution (DC) Account
Withdrawals Before Retirement	**None** – members are not eligible for the Defined Benefit until they reach age and service requirements and separate from employment.	**Members who are not separated from service** ■ Members working in PERF Hybrid Plan covered positions who are *at least* age 59½ AND eligible for full retirement benefits may take a DC withdrawal while still working. ■ Members working in positions NOT covered by the PERF Hybrid Plan who are at least age 59½ may also take a DC withdrawal while still working. **Members who are disabled or separated from service** ■ May leave account invested in PERF or receive a distribution ■ May roll over DC account to a qualified plan or other eligible retirement account
Income and Options at Retirement	**Monthly benefit for life** ■ Monthly amount determined by: 1. Age 2. Years of service 3. Average of annual compensation (Final Average Salary) based on 20 quarters 4. Multiplier of 1.1 percent (.011) ■ Taxable as ordinary income ■ Survivor designated options are available The monthly benefit amount is affected by the payment option election you make at retirement. ■ Any Cost of Living Adjustments (COLAs) must first be approved by the Indiana General Assembly. ■ Greater years of service and/or higher compensation can result in a larger benefit.	**Choices determine payments** ■ May choose monthly payment for lifetime benefit ■ May defer payment until age 72 ■ May choose direct payment or rollover distribution ■ Amount of distribution determined by account balance, taxes withheld, and distribution option chosen.
Beneficiaries	**Monthly payment** ■ Following death of retired member under applicable payment options ■ Following death of active member in limited circumstances	**Balance payment** ■ Receives total accumulated amount after death of active members or retired members who elected to defer payment ■ Receives remainder of accumulated amount per retirement payment options chosen by member

FOR YOUR BENEFIT

This handout is an overview of PERF's plan provisions. Complete details of the fund's provisions are available in the current member handbook. You may read it or print your own copy from the INPRS website at bit.ly/perfhybridmbrhandbook. You may also request a copy in writing or by calling our toll-free number, (844) GO-INPRS.

Keep your information current. Report any changes in your name, address or beneficiary choices directly to INPRS. This is NOT something your employer can do for you. To change your beneficiary, name or address information, visit myINPRSretirement.org.

Every attempt has been made to verify that the information in this publication is correct and up-to-date. Published content does not constitute legal advice. If a conflict arises between information contained in this publication and the law, the applicable law shall apply.

One North Capitol, Suite 001 · Indianapolis, IN 46204 · toll-free: (844) GO-INPRS · www.inprs.in.gov

Notices

Women's Health and 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 consultation with the attending physician and the patient for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, please call your Plan Administrator.

Newborns' and Mothers' Health Protection Act

Newborns' and Mothers' Health Protection Act requires that group health plans and health insurance issuers who offer childbirth coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Refer to your plan document for specific information about childbirth coverage or contact your plan administrator.

Grandfathered Notice

The City of Fort Wayne believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Benefits Department at (260) 427-2634. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself 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 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within 60 days after you or your dependents become eligible for the premium assistance.

To request special enrollment or obtain more information, contact the plan's General Contact.

Medicare Part D Notice

Important Notice from the City of Fort Wayne (we or us) About Your Prescription Drug Coverage under the City of Fort Wayne Employee Benefit Plan (our plan) and Medicare Part D Prescription Drug Coverage

Important: This Notice applies to you only if you are a Part D eligible individual. A Part D eligible individual is someone who has coverage under Medicare Part A or Part B which may include active employees, disabled employees, COBRA participants, retirees, and their covered spouses and dependents. If you do not currently have Medicare Part A or Part B and have not recently applied for Medicare Part A or Part B, then this Notice does not apply to you.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with us 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 prescription 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. We have determined that the prescription drug coverage offered by our plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is 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

Notices

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 through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will 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 do decide to join a Medicare drug plan and drop your medical expense coverage under our plan including your prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. Your prescription drug coverage under our plan is described in the Summary Plan Description we provided you. The portion of the cost of covered prescription drugs you are required to pay is indicated in the Schedule of Benefits. While you continue to be eligible for coverage under our plan, you will not lose coverage under our plan just because you choose to enroll for Medicare prescription drug coverage. However only drugs obtained in accordance with the requirements of our plan will be covered under our plan.

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

For more information about this notice or your current prescription drug coverage…
Contact our office for further information. **NOTE**: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through our plan changes. You also may request a copy of this notice at any time.

For more information about 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 prescription drug plans. For more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see 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.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) on the web at www.socialsecurity.gov, or you 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:	September 21, 2023
Name of Entity/Sender:	City of Fort Wayne
Contact--Position/Office:	HR/Benefits Manager
Address:	200 East Berry, Suite 370 Fort Wayne IN 46802
Phone Number:	(260) 427-2634

Notices

CITY OF FORT WAYNE PLAN COBRA NOTIFICATION

Consolidated Omnibus Budget Reconciliation Act

VERY IMPORTANT NOTICE! Please share this information with your spouse and dependents.

To provide options for individuals who lose health coverage from an employer-sponsored insurance plan, the Federal Government enacted the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272, Title X), commonly known as "COBRA."

COBRA LAW With the exception of church groups and the Federal Government, employers with twenty (20) or more employees (number of employees may vary by state) that provide health benefits are subject to offering employees (and/or their covered dependents) the right to a temporary extension of group insurance (called "continuation coverage") upon experiencing a "qualifying event." We request that you (and your covered dependents) take the time to read this important notification.

This procedure is different from converting to individual coverage after termination of employment. The major advantages are that participants cannot be discriminated against for having a pre-existing medical condition and will be charged the company's group rate (plus a two percent administrative fee). These COBRA rates may (or may not) be less than premiums under a conversion so it is recommended that you contact the insurer to receive a quote. With many conversion plans, covered benefits are reduced. Under COBRA continuation, your benefits would remain identical to the group plan's coverage. COBRA also allows for covered dependents to independently continue their health coverage when lost through a "qualifying event."

EMPLOYER AND QUALIFIER'S RESPONSIBILITIES When an employee or dependent has experienced a "qualifying event," they will be sent notification of their rights to elect COBRA continuation coverage. Employers shall provide this notification within fourteen (14) days from the date group coverage would be terminated (or as soon as administratively possible). The employee or dependent has the responsibility to notify our office of their desire to continue coverage within sixty (60) days from the later of the date of notification or loss of coverage. Upon acceptance, the qualifier(s) would be notified of any enrollment forms that must be completed. Keep in mind, qualifier(s) electing continuation coverage are responsible for premiums back to the date termination from the plan would have occurred.

PARTICIPANT NOTIFICATION REQUIREMENT The City of Fort Wayne will not know when certain "qualifying events" occur. The Employee or Covered Dependent will be responsible for notifying our office of a Divorce, Legal Separation or when a dependent loses his/her "dependent status." The employee or affected dependent has sixty days (election period) to notify our office of the "qualifying event" and their desire to continue coverage. If we are not notified within this time frame, COBRA continuation cannot be offered.

The employee (and/or dependent) will not have coverage during the sixty day election period. Only if he/she elects to continue coverage and pays the applicable premiums will benefits be paid during this time frame.

COBRA QUALIFYING EVENTS Listed below are "qualifying events" for which the employee and/or covered dependents are able to continue their health coverage under the COBRA legislation. As shown, the maximum continuation coverage time frame depends on the "qualifying event" experienced. For someone to be considered a "qualified beneficiary," they must have been enrolled on the group plan on the day prior to the "qualifying event." One exception to this rule is when a child is born to (or placed for adoption with) an employee during the COBRA continuation period. These children will receive all rights of a "qualified beneficiary" throughout the COBRA continuation period. In the past, employers did not have to offer COBRA continuation to qualifiers that had alternative coverage (Medicare or other group insurance). A recent Supreme Court ruling stated that COBRA must be offered to qualifiers even if they have other coverage at the time of the "qualifying event."

Qualifying Events That Yield a Maximum of 18 Months (Experienced by the Employee)

1. Termination of Employment (for reason other then "gross misconduct");
2. Reduction of Employee's Work Hours.

Qualifying Events That Yield a Maximum of 36 Months (Experienced by a covered Dependent)

1. Death of the Employee;
2. Divorce or Legal Separation;
3. Employee qualifies for Medicare but dependents do not;
4. Dependent Child who no longer meets the insurer's definition of a "dependent".

BECOMING DISABLED - In the event of an employee's termination or reduction in work hours, employees or covered dependents who become classified as "disabled" by Social Security (under Title 11 or Title XVI) within the first sixty days of COBRA continuation are eligible for an additional 11 months of coverage (yielding a total of 29 months). For this extension to apply, evidence of disability under the Social Security Act must be provided to the employer within the initial 18 month continuation coverage time frame and within 60 days from the date of the Social Security Administration's determination.

Benefits & Wellness Department | Laura Helmkamp @ 427.2634 | Katie Adams @ 427.6910

Notices

FAMILY AND MEDICAL LEAVE ACT Effective August 5, 1993, the Family and Medical Leave Act of 1993 (FMLA) was enacted to allow eligible employees the right to take up to 12 weeks of unpaid leave to care for themselves or a relative. If you elect to take this leave and later notify the company that you will not be returning, you have the ability to continue your coverage for 18 months from the date benefits are terminated.

MULTIPLE QUALIFYING EVENTS If an employee experiences termination, reduced work hours or is considered "disabled," elects to continue coverage and a covered dependent experiences a second "qualifying event," the dependent may increase their maximum time frame under COBRA from 18 (or 29 for a disability) to 36 months. The maximum continuation period for any qualifying event is thirty-six (36) months. As stated earlier, it is the responsibility of the employee or covered dependent to notify our office within 60 days of the second "qualifying event."

COBRA TERMINATION COBRA continuation coverage has maximum time frames but you may voluntarily terminate coverage at anytime by notifying our office in advance. The COBRA legislation provides the employer the right to terminate continuation coverage for one or more of the following reasons:

1. The company terminates the plan(s) (you are continuing) for all active employees;
2. The COBRA premiums are not paid in a timely manner;
3. If the employee and/or covered dependents become covered under another group plan. (However, if the new plan excludes a covered person's medical pre-existing condition, that person may continue under the COBRA continuation coverage. The Health Insurance Portability and Accountability Act of 1996 limits maximum time frames for pre-existing conditions, therefore a person with prior creditable coverage exceeding the pre-existing limitation period of the new group plan may be terminated by the employer); or
4. An employee becomes entitled to Medicare. (Dependent's continuation coverage may be extended to 36 months upon notifying our office of the employee's Medicare entitlement.)

PREMIUM COSTS The cost of continuation coverage will be determined at the time of the "qualifying event." Your cost will be the amount the insurance company charges the City of Fort Wayne for active employees (with similar coverage type) plus a 2% administration fee. If the insurer delivers a premium increase or reduction, the COBRA participant's premiums will be adjusted accordingly.

CONVERSION TO AN INDIVIDUAL PLAN A conversion plan allows individuals covered under a group plan to convert their coverage to an individual plan without a lapse in coverage or pre-existing condition limitations upon termination from the group plan. Not all group plans are subject to offering a conversion. If you are enrolled in a plan that allows conversions, our firm will send notification explaining conversion privileges in the last 180 days of your COBRA term.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 With the signing of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), COBRA's rules changed creating further options to individuals losing insurance coverage under a group plan. The law further defined the "Disability Extension," Eligible COBRA Qualifying Beneficiaries and when a coverage can be terminated from COBRA due to new coverage under another group plan.

The scope of the law is to eliminate barriers for individuals (mainly people with medical pre-existing conditions that would have difficulty obtaining immediate coverage) who lose coverage and want to find some form of replacement plan. Effective dates for most of the provisions will vary depending on the contract renewal date of group plans but all employers should be responsible for the law by June 30, 1998.

The law limits a plan's "pre-existing condition limitation time frame" to twelve (12) months for newly enrolling individuals and provides credit for prior coverage. A Certificate of Coverage will be provided when you terminate from a group plan that illustrates coverage under that program. This certificate should be shown to a new employer to receive the one month credit for every month of prior coverage. Keep in mind, that if there is a break in coverage greater than sixty-three (63) days, the new employer does not have to provide any prior coverage credit. In addition, if you elect COBRA and exhaust either the eighteen (18) or thirty-six (36) months maximum time frame, you may be eligible for coverage under an individual plan (through an insurer of your choice) on a guaranteed issue basis without any pre-existing condition limitations.

Lastly, HIPAA allows individuals to pay for their COBRA premiums from withdrawals from an Individual Retirement Account (IRA). After December 31, 1996, withdrawals may be made penalty free (usually 10%) for medical insurance if the individual has received unemployment compensation under federal or state law for at least twelve (12) weeks. This provision only eliminates the 10% penalty fee and not the standard income tax.

INSURANCE PLAN REQUIREMENTS Some group insurance plans require members to receive services from contracted providers. If you elect COBRA continuation coverage and move from the insurer's "service area," your coverage cannot be continued under the group plan.

ACCEPTANCE PROCEDURES Upon receiving the COBRA Qualifying Event notification, the qualifier will be responsible for completing the appropriate forms and returning them to the administrator prior to the end of the sixty day election period. Even though there is a forty-five day grace period, we recommend that all premiums (back to the date coverage was terminated) be paid with the submission of the COBRA applications. From that point on, it is the qualifier/COBRA participant's responsibility to make premium payments in a timely fashion. COBRA premiums shall be prepaid and due on the first of the month. The law provides a thirty-one day grace period for all premium payments after the initial payment. If payment is not received within this time frame, COBRA coverage will be terminated.

QUESTIONS REGARDING COBRA If you have any questions regarding this notification of your COBRA rights, please feel free to contact The Benefits & Wellness Department during working hours.

Benefits & Wellness Department | Laura Helmkamp @ 427.2634 | Katie Adams @ 427.6910

Notices

EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:
- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements
Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:
- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV

WHD
U.S. Wage and Hour Division

U.S. Department of Labor | Employment Standards Administration | Wage and Hour Division

WHD Publication 1420 Revised January 2009

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

ALABAMA – Medicaid	MASSACHUSETTS – Medicaid and CHIP	PENNSYLVANIA – Medicaid and CHIP
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 / TTY: 711 Email: masspremassistance@accenture.com	Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP)(pa.gov) CHIP Phone: 1-800-986-KIDS (5437)
ALASKA – Medicaid	**MINNESOTA – Medicaid**	**RHODE ISLAND – Medicaid and CHIP**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
ARKANSAS – Medicaid	**MISSOURI – Medicaid**	**SOUTH CAROLINA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
CALIFORNIA – Medicaid	**MONTANA – Medicaid**	**SOUTH DAKOTA - Medicaid**
Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 / Fax: 916-440-5676 / Email: hipp@dhcs.ca.gov	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://dss.sd.gov Phone: 1-888-828-0059
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**NEBRASKA – Medicaid**	**TEXAS – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Center: 1-800-221-3943 / State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 / State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
FLORIDA – Medicaid	**NEVADA – Medicaid**	**UTAH – Medicaid and CHIP**
Website: https://flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
GEORGIA – Medicaid	**NEW HAMPSHIRE – Medicaid**	**VERMONT– Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
INDIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**	**VIRGINIA – Medicaid and CHIP**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://covera.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-prgrams Medicaid/CHIP Phone: 1-800-432-5924
IOWA – Medicaid and CHIP (Hawki)	**NEW YORK – Medicaid**	**WASHINGTON – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/Medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://www.hca.wa.gov/ Medicaid/CHIP Phone: 1-800-562-3022
KANSAS – Medicaid	**NORTH CAROLINA – Medicaid**	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
KENTUCKY – Medicaid	**NORTH DAKOTA – Medicaid**	**WISCONSIN – Medicaid and CHIP**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 / Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
LOUISIANA – Medicaid	**OKLAHOMA – Medicaid and CHIP**	**WYOMING – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269
MAINE – Medicaid	**OREGON – Medicaid**	
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 / TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 / TTY: Maine relay 711	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor	U.S. Department of Health and Human Services
Employee Benefits Security Administration	Centers for Medicare & Medicaid Services
www.dol.gov/agencies/ebsa	**www.cms.hhs.gov**
1-866-444-EBSA (3272)	1-877-267-2323, Menu Option 4, Ext. 61565

Notices

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new 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 new 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 new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% 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.[1]

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 Laura Helmkamp, City of Fort Wayne, (260) 427-2634

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

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Notices

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name City of Fort Wayne		4. Employer Identification Number (EIN) 35-6001029
5. Employer address 200 East Berry		6. Employer phone number 260-427-2634
7. City Fort Wayne	8. State IN	9. ZIP code 46802
10. Who can we contact about employee health coverage at this job? Laura Helmkamp		
11. Phone number (if different from above) 260-427-2634	12. Email address Laura.Helmkamp@cityoffortwayne.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☑ Some employees. Eligible employees are:

    All full-time employees

- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:

    Spouse & Dependent children

  - ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

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The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?____________________ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $______________
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?______________
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $______________
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Notices

CITY OF FORT WAYNE
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 of Privacy Practices describes how protected health information (or "PHI") may be used or disclosed by City of Fort Wayne Group Health Plan (we/us) to carry out payment, health care operations, and for other purposes that are permitted or required by law. This Notice also sets out our legal obligations concerning your PHI, and describes your rights to access, amend and manage your PHI.

PHI is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer (when functioning on behalf of the group health plan), or a health care clearing-house and that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you. This Notice of Privacy Practices had been drafted to be consistent with what is known as the "HIPAA Privacy Rule," and any of the terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Rule.

If you have any questions or want additional information about the Notice or the policies and procedures described in the Notice, please contact:

Title: _____Benefits Manager____

Name: ____Laura Helmkamp____

Address: __200 E. Berry, Suite 370, Fort Wayne, IN 46802______________________

Telephone Number: _(260) 427-2634____

EFFECTIVE DATE

This Notice of Privacy Practices becomes effective on __September 23, 2013_________.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy of your PHI. We are obligated to: provide you with a copy of this Notice of our legal duties and of our privacy practices related to your PHI; abide by the terms of the Notice that is currently in effect; and notify you in the event of a breach of your unsecured PHI. We reserve the right to change the provisions of our Notice and make the new provisions effective for all PHI that we maintain. If we make a material change to our Notice, we will make the revised Notice available upon request. **[This Notice is on our Website and is available electronically]**.

Notices

Permissible Uses and Disclosures of PHI

The following is a description of how we are most likely to use and/or disclose your PHI.

- ***Payment and Health Care Operations.*** We have the right to use and disclose your PHI for all activities that are included within the definitions of "payment" and "health care operations" as set out in 45 C.F.R. § 164.501 (this provision is a part of the HIPAA Privacy Rule). We have not listed in this Notice all of the activities included within these definitions, so please refer to 45 C.F.R. § 164.501 for a complete list.

  - *Payment*
    We will use or disclose your PHI to pay claims for services provided to you and to obtain stop-loss reimbursements or to otherwise fulfill our responsibilities for coverage and providing benefits. For example, we may disclose your PHI when a provider requests information regarding your eligibility for coverage under our health plan, or we may use your information to determine if a treatment that you received was medically necessary.

  - *Health Care Operations*
    We will use or disclose your PHI to support our business functions. These functions include, but are not limited to: quality assessment and improvement, reviewing provider performance, licensing, stop-loss underwriting, business planning, and business development. For example, we may use or disclose your PHI: (i) to provide you with information about a disease management program; (ii) to respond to a customer service inquiry from you; or (iii) in connection with fraud and abuse detection and compliance programs.

Other Permissible Uses and Disclosures of PHI

The following is a description of other possible ways in which we may (and are permitted to) use and/or disclose your PHI.

- ***Required by Law.*** We may use or disclose your PHI to the extent the law requires the use or disclosure. When used in this Notice, "required by law" is defined as it is in the HIPAA Privacy Rule. For example, we may disclose your PHI when required by national security laws or public health disclosure laws.

- ***Public Health Activities.*** We may use or disclose your PHI for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or we may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. We also may disclose PHI, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

- ***Health Oversight Activities.*** We may disclose your PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

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- ***Abuse or Neglect.*** We may disclose your PHI to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, we may disclose to a governmental entity authorized to receive such information your PHI if we believe that you have been a victim of abuse, neglect, or domestic violence.

- ***Legal Proceedings.*** We may disclose your PHI: (i) in the course of any judicial or administrative proceeding; (ii) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (iii) in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your PHI in response to a subpoena for such information, but only after we first meet certain conditions required by the HIPAA Privacy Rule.

- ***Law Enforcement.*** Under certain conditions, we also may disclose your PHI to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (i) it is required by law or some other legal process; (ii) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person; and (iii) it is necessary to provide evidence of a crime that occurred on our premises.

- ***Coroners, Medical Examiners, Funeral Directors; Organ Donation Organizations.*** We may disclose PHI to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose PHI to organizations that handle organ, eye, or tissue donation and transplantation.

- ***Research.*** We may disclose your PHI to researchers when an institutional review board or privacy board has: (i) reviewed the research proposal and established protocols to ensure the privacy of the information; and (ii) approved the research.

- ***To Prevent a Serious Threat to Health or Safety.*** Consistent with applicable federal and state laws, we may disclose your PHI if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We also may disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

- ***Military Activity and National Security, Protective Services.*** Under certain conditions, we may disclose your PHI if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose your PHI to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

- ***Inmates.*** If you are an inmate of a correctional institution, we may disclose your PHI to the correctional institution or to a law enforcement official for: (i) the institution to provide health care to you; (ii) your health and safety and the health and safety of others; or (iii) the safety and security of the correctional institution.

- ***Workers' Compensation.*** We may disclose your PHI to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

- ***Emergency Situations.*** We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previous identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interests. If the disclosure is in your best interest, we will disclose only the PHI that is directly relevant to the person's involvement in your care.

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- ***Fundraising Activities.*** We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance its activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.

- ***Group Health Plan Disclosures.*** We may disclose your PHI to a sponsor of the group health plan – such as an employer or other entity – that is providing a health care program to you. We can disclose your PHI to that entity if that entity has contracted with us to administer your health care program on its behalf.

- ***Underwriting Purposes.*** We may use or disclose your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing in the underwriting process your PHI that is genetic information.

- ***Others Involved in Your Health Care.*** Using our best judgment, we may make your PHI known to a family member, other relative, close personal friend or other personal representative that you identify. Such a use will be based on how involved the person is in your care, or payment that relates to your care. We may release information to parents or guardians, if allowed by law. If you are not present or able to agree to these disclosures of your PHI, then, using our professional judgment, we may determine whether the disclosure is in your best interest.

Uses and Disclosures of Your PHI that Require Your Authorization

Sale of PHI

We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.

Marketing

We will request your written authorization to use or disclose your PHI for marketing purposes with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.

Psychotherapy Notes

We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or health care operation functions.

Other uses and disclosures of your PHI that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

Required Disclosures of Your PHI

The following is a description of disclosures that we are required by law to make.

- ***Disclosures to the Secretary of the U.S. Department of Health and Human Services.*** We are required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

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- ***Disclosures to You*** We are required to disclose to you most of your PHI in a "designated record set" when you request access to this information. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. We also are required to provide, upon your request, an accounting of most disclosures of your PHI that are for reasons other than payment and health care operations and are not disclosed through a signed authorization.

  We will disclose your PHI to an individual who has been designated by you as your personal representative and who has qualified for such designation in accordance with relevant state law. However, before we will disclose PHI to such a person, you must submit a written notice of his/her designation, along with the documentation that supports his/her qualification (such as a power of attorney).

  Even if you designate a personal representative, the HIPAA Privacy Rule permits us to elect not to treat the person as your personal representative if we have a reasonable belief that: (i) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; (ii) treating such person as your personal representative could endanger you; or
  (iii) we determine, in the exercise of our professional judgment, that it is not in your best interest to treat the person as your personal representative.

- ***Business Associates.*** We contract with individuals and entities (Business Associates) to perform various functions on our behalf or to provide certain types of services. To perform these functions or to provide the services, our Business Associates will receive, create, maintain, use, or disclose PHI, but only after we require the Business Associates to agree in writing to contract terms designed to appropriately safeguard your information. For example, we may disclose your PHI to a Business Associate to administer claims or to provide member service support, utilization management, subrogation, or pharmacy benefit management. Examples of our business associates would be our Third Party Administrator, which will be handling many of the functions in connection with the operation of our Group Health Plan; the retail pharmacy; and the mail order pharmacy.

- ***Other Covered Entities.*** We may use or disclose your PHI to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with payment activities and certain health care operations. For example, we may disclose your PHI to a health care provider when needed by the provider to render treatment to you, and we may disclose PHI to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing. This also means that we may disclose or share your PHI with other insurance carriers in order to coordinate benefits, if you or your family members have coverage through another carrier.

- ***Plan Sponsor.*** We may disclose your PHI to the plan sponsor of the Group Health Plan for purposes of plan administration or pursuant to an authorization request signed by you.

Potential Impact of State Law

The HIPAA Privacy Rule regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

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YOUR RIGHTS

The following is a description of your rights with respect to your PHI.

- ***Right to Request a Restriction.*** You have the right to request a restriction on the PHI we use or disclose about you for payment or health care operations. *We are not required to agree to any restriction that you may request.* If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you. You may request a restriction by contacting the designated contact listed on the first page of this Notice. It is important that you direct your request for restriction to the designated contact so that we can begin to process your request. Requests sent to persons or offices other than the designated contact might delay processing the request.

  We will want to receive this information in writing and will instruct you where to send your request when you call. In your request, please tell us: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

- ***Right to Request Confidential Communications.*** If you believe that a disclosure of all or part of your PHI may endanger you, you may request that we communicate with you regarding your information in an alternative manner or at an alternative location. For example, you may ask that we only contact you at your work address or via your work e-mail.

  You may request a restriction by contacting the designated contact listed on the first page of this Notice. It is important that you direct your request for confidential communications to the designated contact so that we can begin to process your request. Requests sent to persons or offices other than the one indicated might delay processing the request.

  We will want to receive this information in writing and will instruct you where to send your written request when you call. In your request, please tell us: (1) that you want us to communicate your PHI with you in an alternative manner or at an alternative location; and (2) that the disclosure of all or part of the PHI in a manner inconsistent with your instructions would put you in danger.

  We will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of your PHI could endanger you. As permitted by the HIPAA Privacy Rule, "reasonableness" will (and is permitted to) include, when appropriate, making alternate arrangements regarding payment.

  Accordingly, as a condition of granting your request, you will be required to provide us information concerning how payment will be handled. For example, if you submit a claim for payment, state or federal law (or our own contractual obligations) may require that we disclose certain financial claim information to the plan participant (*e.g.*, an Explanation of Benefits, or "EOB"). *Unless* you have made other payment arrangements, the EOB (in which your PHI might be included) will be released to the plan participant.

  Once we receive all of the information for such a request (along with the instructions for handling future communications), the request will be processed usually within three business days.

  Prior to receiving the information necessary for this request, or during the time it takes to process it, PHI might be disclosed (such as through an EOB). Therefore, it is extremely important that you contact the designated contact listed on the first page of this Notice *as soon as* you determine that you need to restrict disclosures of your PHI.

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If you terminate your request for confidential communications, the restriction will be removed for *all* your PHI that we hold, including PHI that was previously protected. Therefore, you should not terminate a request for confidential communications if you remain concerned that disclosure of your PHI will endanger you.

- ***Right to Inspect and Copy.*** You have the right to inspect and copy your PHI that is contained in a "designated record set." Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

  To inspect and copy your PHI that is contained in a designated record set, you must submit your request to the designated contact listed on the first page of this Notice. It is important that you contact the designated contact to request an inspection and copying so that we can begin to process your request. Requests sent to persons, offices, other than the designated contact might delay processing the request. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy your PHI in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. To request a review, you must contact the designated contact listed on the first page of this Notice. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

- ***Right to Amend.*** If you believe that your PHI is incorrect or incomplete, you may request that we amend your information. You may request that we amend your information by contacting the designated contact listed on the first page of this Notice. Additionally, your request should include the reason the amendment is necessary. It is important that you direct your request for amendment to the designated contact so that we can begin to process your request. Requests sent to persons or offices, other than the designated contact might delay processing the request.

  In certain cases, we may deny your request for an amendment. For example, we may deny your request if the information you want to amend is not maintained by us, but by another entity. If we deny your request, you have the right to file a statement of disagreement with us. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

- ***Right of an Accounting.*** You have a right to an accounting of certain disclosures of your PHI that are for reasons other than treatment, payment, or health care operations. No accounting of disclosures is required for disclosures made pursuant to a signed authorization by you or your personal representative. You should know that most disclosures of PHI will be for purposes of payment or health care operations, and, therefore, will not be subject to your right to an accounting. There also are other exceptions to this right. An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

  You may request an accounting by submitting your request in writing to the designated contact listed on the first page of this Notice. It is important that you direct your request for an accounting to the designated contact so that we can begin to process your request. Requests sent to persons or offices other than the designated contact might delay processing the request.

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Your request may be for disclosures made up to 6 years before the date of your request, but not for disclosures made before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

- ***Right to a Copy of This Notice.*** You have the right to request a copy of this Notice at any time by contacting the designated contact listed on the first page of this Notice. If you receive this Notice on our Website or by electronic mail, you also are entitled to request a paper copy of this Notice.

COMPLAINTS

You may complain to us if you believe that we have violated your privacy rights. You may file a complaint with us by calling us at the number listed on the first page of this Notice. A copy of a complaint form is available from this contact office.

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem.

We will not penalize or any other way retaliate against you for filing a complaint with the Secretary or with us.

Notes