NORTHWEST HEALTH SERVICES

We ♥ our employees!

2025 EMPLOYEE BENEFITS BROCHURE

Medical - HSA

	Network	Non-Network
Deductible		
Individual	$3,300	$3,300
Family	$6,600	$6,600
Member Coinsurance	0%	20%
Out-of-Pocket Maximum (Includes deductible, co-insurance, per visit and RX copays)		
Individual	$3,300	$6,600
Family	$6,600	$13,200
Common Services		
Physician Office Visits		
Primary Care	Deductible then 0%	Deductible then 20%
Specialist	Deductible then 0%	Deductible then 20%
Hospital Services Inpatient & Outpatient	Deductible then 0%	Deductible then 20%
Diagnostic Lab & X-Ray	Deductible then 0%	Deductible then 20%
Urgent Care (Includes lab only)	Deductible then 0%	Deductible then 20%
Emergency Room	Deductible then 0%	
Preventive Services (Includes Well Woman Exam, Prostate Exam, Skin Cancer Screening, Routine Physical Exam, and Well Baby Care)	Covered at 100% (Deductible Waived)	Deductible then 20%
Prescription Drugs 30-day - Retail (90-day mail order twice the retail copay)		
Generic	Deductible then 0%	Deductible then 50%
Brand - Preferred	Deductible then 0%	Deductible then 50%
Brand - Non-Preferred	Deductible then 0%	Deductible then 50%

HSA Medical Rates - Cost Per Pay Period	
Employee Only	$26.30
Employee Spouse	$147.45
Employee Child(ren)	$126.27
Family	$218.43

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Medical - Base

Kansas City

	Network	Non-Network
Deductible		
Individual	$2,800	$2,800
Family	$5,600	$5,600
Member Coinsurance	0%	20%
Out-of-Pocket Maximum (Includes deductible, co-insurance, per visit and RX copays)		
Individual	$2,800	$5,600
Family	$5,600	$11,200
Common Services		
Physician Office Visits		
Primary Care	$10 Copay, then 0%	$10 Copay, then 20%
Specialist	$30 Copay, then 0%	$30 Copay, then 20%
Hospital Services Inpatient & Outpatient	Deductible then 0%	Deductible then 20%
Diagnostic Lab & X-Ray	Deductible then 0%	Deductible then 20%
Urgent Care (Includes lab only)	Deductible then 0%	Deductible then 20%
Emergency Room	Deductible then 0%	
Preventive Services (Includes Well Woman Exam, Prostate Exam, Skin Cancer Screening, Routine Physical Exam, and Well Baby Care)	Covered at 100% (Deductible Waived)	Deductible then 20%
Prescription Drugs 30-day - Retail (90-day mail order twice the retail copay)		
Generic	$15 Copay	Deductible then 50% + $15 Copay
Brand - Preferred	$35 Copay	Deductible then 50% + $30 Copay
Brand - Non-Preferred	$70 Copay	Deductible then 50% + $70 Copay

NHS Medical Rates - Cost Per Pay Period	
Employee Only	$31.29
Employee Spouse	$156.15
Employee Child(ren)	$135.37
Family	$231.42

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Medical - Buy-Up

	Network	Non-Network
Deductible		
Individual	$1,000	$1,000
Family	$2,000	$2,000
Member Coinsurance	20%	40%
Out-of-Pocket Maximum (Includes deductible, co-insurance, per visit and RX copays)		
Individual	$3,000	$6,000
Family	$6,000	$12,000
Common Services		
Physician Office Visits		
Primary Care	$10 Copay, then 20%	Deductible then 40%
Specialist	$30 Copay, then 20%	Deductible then 40%
Hospital Services Inpatient & Outpatient	Deductible then 20%	Deductible then 40%
Diagnostic Lab & X-Ray	Deductible then 20%	Deductible then 40%
Urgent Care (Includes lab only)	$30 Copay, then 20%	Deductible then 40%
Emergency Room	$150 Copay	
Preventive Services (Includes Well Woman Exam, Prostate Exam, Skin Cancer Screening, Routine Physical Exam, and Well Baby Care)	Covered at 100% (Deductible & Copay Waived)	Deductible then 40%
Prescription Drugs 30-day - Retail (90-day mail order twice the retail copay)		
Generic	$10 Copay	Deductible then 50% + $10 Copay
Brand - Preferred	$30 Copay	Deductible then 50% + $30 Copay
Brand - Non-Preferred	$50 Copay	Deductible then 50% + $50 Copay

Buy-Up Medical Rates - Cost Per Pay Period	
Employee Only	$59.13
Employee Spouse	$204.71
Employee Child(ren)	$186.24
Family	$303.95

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Dental

Predetermination of Benefits: Before treatment begins for inlays, onlays, single crowns, prosthetics, periodontics and oral surgery, you may file a dental treatment plan with Guardian. Guardian will provide a written response indicating benefits that may be payable for the proposed treatment.

This chart provides you a brief summary of the key benefits of the dental coverage available from Guardian. For a complete list of all your dental coverage benefits and restrictions, please see your official plan documents.

PPO Plan		
	In-Network DentalGuard Preferred Network	Non-Network
Calendar Year Deductible		
Individual	$25	$50
Family Limit	$75	$150
Waived For	Preventive	Preventive
Charges Covered For You (Co-Insurance)		
Preventive Care	100%	100%
Basic Care	100%	100%
Major Care	80%	80%
Orthodontia (under age 19)	25%	25%
Benefit Maximum		
Annual Maximum Benefit	$2,000	
Preventive Services Exempt from Maximum	Yes	
Lifetime Orthodontia Maximum	$1,500	
Dependent Age Limit	26	
Maximum Rollover		
To qualify for a $1,250 Maximum Rollover Account, you must have a paid claim (not just a visit) and must not have exceeded the paid claims threshold during the benefit year. See your official plan documents for more detail.		

Dental Rates	
	Cost Per Pay Period
Employee Only	$0.00
Employee Spouse	$17.60
Employee Child(ren)	$17.82
Family	$36.89

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Vision

eye med

Additional Discounts

40% OFF
Complete pair of prescription eyeglasses

20% OFF
Non-prescription sunglasses

20% OFF
Remaining balance beyond plan coverage

These discounts are for in-network providers only

Take a sneak peek before enrolling

- You're on the INSIGHT Network
- For a complete list of **in-network** providers near you, use our **Enhanced** Provider Locator on www.eyemed.com or call **1-866-804-0982**.
- For Lasik providers, call 1-877-5LASER6.

SUMMARY OF BENEFITS

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam With Dilation as Necessary	$10 Co-pay	Up to $40
Retinal Imaging	Up to $39	N/A
Frames	$0 Co-pay; $130 allowance; 20% off balance over $130	Up to $91
Standard Plastic Lenses		
Single Vision	$25 Co-pay	Up to $30
Bifocal	$25 Co-pay	Up to $50
Trifocal	$25 Co-pay	Up to $70
Standard Progressive Lens	$90 Co-pay	Up to $50
Premium Progressive Lens△	$110 Co-pay - $135 Co-pay	
Tier 1	$110 Co-pay	Up to $50
Tier 2	$120 Co-pay	Up to $50
Tier 3	$135 Co-pay	Up to $50
Tier 4	$90 Co-pay, 80% of charge less $120 Allowance	Up to $50
Lenticular	$25 Co-pay	Up to $70
Lens Options (paid by the member and added to the base price of the lens)		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate	$40	N/A
Standard Polycarbonate - Kids under 19	$40	N/A
Standard Anti-Reflective Coating	$45	N/A
Premium Anti-Reflective Coating△	$57 - $68	N/A
Tier 1	$57	N/A
Tier 2	$68	N/A
Tier 3	80% of charge	N/A
Photochromic/Transitions	$75	N/A
Polarized	20% off retail price	N/A
Other Add-Ons and Services	20% off retail price	N/A
Contact Lens Fit and Follow-Up (Contact lens fit and two follow up visits are available once a comprehensive eye exam has been completed)		
Standard Contact Lens Fit & Follow-Up	Up to $55	N/A
Premium Contact Lens Fit & Follow-Up	10% off retail	N/A
Contact Lenses		
Conventional	$0 Co-pay; $130 allowance; 15% off balance over $130	Up to $130
Disposable	$0 Co-pay; $130 allowance; plus balance over $130	Up to $130
Medically Necessary	$0 Co-pay, Paid-in-Full	Up to $210
Laser Vision Correction		
Lasik or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A
Hearing Care		
Hearing Health Care from Amplifon Hearing Network	40% off hearing exams and a low price guarantee on discounted hearing aids	N/A
Frequency		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 24 months	

Vision Rates

	Cost Per Pay Period
Employee Only	$3.18
Employee Spouse	$6.04
Employee Child(ren)	$6.36
Family	$9.35

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Group Life

Employer Paid - to all employees working a minimum of 20 hours a week.

• The benefit is equal to 1x your annual salary, up to $50,000 maximum.

• Beneficiary information can be updated as needed throughout the year.
It is important to have up-to-date information on file with Northwest Health Services.

• Coverage amount(s) will reduce according to the following schedule:
65% at age 70
45% at age 75

Long-term Disability

Employer Paid - to all employees working a minimum of 20 hours a week.

• The benefit is equal to 60% of your base wage to a maximum monthly benefit of $10,000.
• Pre-existing condition exclusion: 3/12.

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Voluntary Life

Employee Paid

Your Term Life and AD&D coverage options are:

Employee: Up to 5 times salary in increments of $10,000
Not to exceed $500,000.

Spouse: Up to 100% of employee amount in increments of $5,000.
Not to exceed $500,000. Benefits will be paid to the employee.

Child: Up to 100% of employee coverage amount in increments of $5,000.
Not to exceed $10,000.
The maximum death benefits for a child between the ages of live birth and 6 months is $1,000. Benefits will be paid to the employee.

If you and your eligible dependents enroll within 31 days of your eligibility date, you may apply for any amount of life insurance coverage up to $140,000 for yourself and any amount of coverage up to $30,000 for your spouse. Any life insurance coverage over the Guarantee Issue amount(s) will be subject to evidence of insurability.
If you and your eligible dependents do not enroll within 31 days of your eligibility date, you can apply for coverage only during your annual enrollment period and will be required to furnish evidence of insurability for the entire amount of coverage.

Rates

Employee Age	Employee Monthly Rate Per $10,000		Spouse Monthly Per $5,000	Child Rate Per $5,000
	Non-Tobacco	Tobacco		
15-24	$0.40	$0.67	$0.20	$1.00
25-29	$0.40	$0.67	$0.20	
30-34	$0.50	$0.87	$0.25	
35-39	$0.78	$1.40	$0.39	
40-44	$1.13	$2.06	$0.57	
45-49	$1.74	$3.24	$0.87	
50-54	$2.84	$5.33	$1.42	
55-59	$4.64	$8.52	$2.32	
60-64	$7.46	$12.82	$3.73	
65-69	$13.99	$22.87	$7.00	
70-74	$28.82	$41.47	$35.08	
75-79	$28.82	$41.47	$57.84	
Voluntary AD&D	**Employee Monthly Rate**		**Spouse Monthly Rate**	**Child Monthly Rate**
	$0.20 Per $1,000		$0.10 Per $5,000	$0.10 Per $5,000

NOTE: Spouse rate is based on employee's insurance age. Your rate will increase as you age and move to the next age band. Your rate is based on your insurance age, which is your age immediately prior to and including the anniversary/ effective date.

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HSA Health Savings Account

UMB

Your UMB Health Savings Account (HSA) is a versatile tool that allows you to decide whether to spend your money to pay for qualified medical expenses or save your money to allow your HSA to grow for future expenses like retirement. Qualified medical expenses are defined by the IRS Code Section 213(d) and include amounts paid for your medical needs.

The IRS requires that you keep itemized receipts to document your withdrawals. Your qualified tax free HSA withdrawals may be expenses made by you, your spouse, or your eligible dependents, regardless of whether they are covered on the medical plan or not.

Start a Savings Plan for Your Health
By enrolling in your company's high-deductible health plan you may be eligible to open and save in a health savings account (HSA) from United Missouri Bank, Member FDIC. Here is some information about how an HSA works and directions for getting started.

What is an HSA?
Think of an HSA as a savings plan for health care you'll need today, tomorrow and into the future. It works like a regular bank account, but you don't pay federal income tax on the money you deposit. When you use your HSA money to pay for qualified medical expenses, you won't pay income taxes on the money, either. You even build your savings into a nest egg for retirement.

Unlike a flexible spending account (FSA), your savings grow from year to year. There's no "use it or lose it" rule. The money is there when you need it. And it's yours to keep.

Why have an HSA?
An HSA simply helps you plan, save and pay for health care.

You own it.
The money belongs to you, even deposits made by others, such as an employer or family member. You keep it, even if you change jobs or health plans.

It has triple tax benefits.

- Money deposited is federal income tax-free.
- Savings grow tax-free.
- Withdrawals made for qualified expenses are also income-tax free.

Anyone can contribute.
You, your employer or a loved-one. There are no restrictions on who can put money into your account.

It's not just for doctor visits.
You can use your HSA to pay for medical needs such as eyeglasses, hearing aids and qualified prescriptions. You can even use your savings to pay for other kinds of health insurance, such as COBRA, long-term care and any health plan coverage you have while receiving unemployment compensation. When you turn 65, you can use HSA savings to pay for any tax deductible health insurance (except for Medicare supplemental insurance).

You can invest it.
Once your balance reaches the investment threshold, you can begin investing in mutual funds. If you earn money on your investments, you don't pay income tax on that money, either.

You can save for the future.
By saving in an HSA, you can be ready for expenses due to illness or accident. And, after you turn 65 or become entitled to Medicare benefits, you may withdraw money from your HSA for expenses that are not qualified medical expenses which are subject to standard income taxes, without penalty. Save as much as you can now, and you could possibly have a nest egg when you retire.

What else you need to know about an HSA
Eligibility rules apply.
To deposit money into an HSA, you must be enrolled in an HSA-eligible health plan. You are eligible if:

- You are covered under an eligible high deductible health plan (HDHP).
- You are covered by no other health coverage, unless it is permissible coverage like vision or dental.
- You are not enrolled in Medicare.
- You cannot be claimed as a dependent on someone else's tax return.

Some other restrictions apply. Please consult your tax, benefits or financial advisor.

If you switch to a health plan that makes you ineligible to continue depositing money in an HSA, you may continue to use the money in your account for qualified medical expenses, but you can no longer make deposits.

Contribution limits are determined every year by the IRS.

For **2025**, you can deposit up to **$4,300** if you have individual coverage and **$8,550** if you have a family policy. The IRS also allows you to make an extra catch-up deposit of **$1,000** if you are 55 or older.

You can make contributions all the way up to the tax-filing deadline (usually April 15) and still get tax credit for the previous year.

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FSA Flexible Spending Account

Southern BANK

A Flexible Spending Account (FSA) is a valuable employee benefit. Under IRS Code 125, employees can set aside pre-tax dollars from their paycheck and be reimbursed with those dollars throughout the year for qualified medical, daycare, and other allowable expenses. Depending on your personal situation, you may want to participate in one or a combination of the available accounts within the FSA. As qualified expenses are incurred, you are reimbursed from the account with your pre-tax dollars. For every dollar set aside from your paycheck to the plan, you save on taxes that are not withheld. By reducing your income taxes, you increase your take-home pay.

Employees have the option to elect a healthcare FSA and/or a dependent care FSA administered by Southern Bank.

Healthcare Flexible Spending Account

Healthcare expenses that are not covered by insurance can be reimbursed through a healthcare FSA. Examples of qualified expenses include copays, deductibles, prescriptions, eye glasses or contacts, dental services, and more.

Annual Contribution Limit for **2024**: **$3,300**

“Use-It-or-Lose-It” Rule: Remember to fund based on your needs. At the end of the plan year, any unused funds will be forfeited, with the exception of **$660**.

Dependent Care Flexible Spending Account - Southern Bank

Dependent care can be costly. Using the Dependent Care FSA, you can pay for qualified care costs for a child or adult . You pay for the expense when incurred, and then submit a reimbursement claim form or file a claim online for reimbursement. Remember that both spouses or custodial parents must be employed and dependent must be:

- A child under age 13 or;
- A child, spouse or other dependent who is physically or mentally incapable of self-care and spends at least 8 hours in your household.

Annual Contribution Limit for **2025**: **$5,000**

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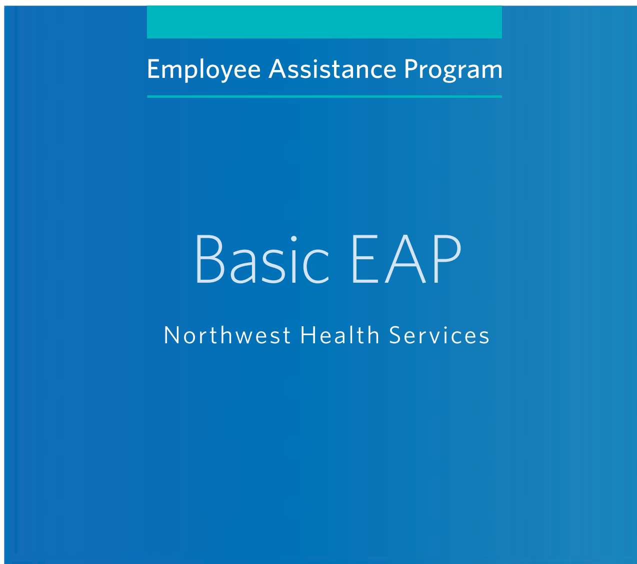

Life's not always easy. Sometimes a personal or professional issue can get in the way of maintaining a healthy, productive life. Your Employee Assistance Program (EAP) can be the answer for you and your family.

We're Here to Help

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

- Emotional Well-Being
- Family and Relationships
- Legal and Financial
- Healthy Life Styles
- Work and Life Transitions

EAP Benefits

- Access to EAP Professionals 24 hours a day, seven days a week
- Provides information and referral resources
- Service for employees and eligible dependents
- Online resources for:
  - *Substance use and other addictions*
  - *Dependent and Elder Care resources*
- Access to a library of educational articles, handouts and resources via **mutualofomaha.com/eap**
  - *Legal library and online forms*
  - *Financial and online tools*

What to Expect

You can trust your EAP professional to assess your needs and handle your concerns in a confidential, respectful manner. Our goal is to collaborate with you and find solutions that are responsive to your needs.

Your EAP benefits are provided through your employer. If additional services are needed, your EAP will help locate appropriate resources in your area.

Don't delay if you need help. Visit mutualofomaha.com/eap or call 800-316-2796 for confidential consultation and resource services.

Mutual of Omaha

Legal Notices

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 towards 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.

Notice of Patient Protections

Your plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you can designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Human Resources Department.

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

Women's Health and Cancer Rights Act

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

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers 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 insurance issuer for prescribing a length of stay in excess of 48 hours (or 96 hours).

HIPAA Privacy

Your employer is required by law to take reasonable steps to ensure the privacy and inform you about the uses of your protected health information (PHI). The use and disclosure of PHI is regulated by the federal law known as HIPAA (the Health Insurance Portability and Accountability Act). A more complete description of your privacy rights and protections is available to you on request. Contact the Human Resources Department with any questions or to request a copy of the full HIPAA privacy notice.

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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, 2024. Contact your State for more information on eligibility –

KANSAS - Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

MISSOURI - Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

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
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Notices

Health Insurance Marketplace Coverage Options & Your Health Coverage

General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

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

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

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

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

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

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

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Notices

Health Insurance Marketplace Coverage Options & Your Health Coverage Cont.

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

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

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan.

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

How Can I Get More Information?

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

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.

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Notices

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn’t in your health plan’s network.

“Out-of-network” describes providers and facilities that haven’t signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “**balance billing**.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan’s in-network cost-sharing amount (such as copayments and coinsurance). You can’t be balance billed for these emergency services. This includes services you may get after you’re in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

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

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

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

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Your Rights and Protections Against Surprise Medical Bills cont.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the entity responsible for enforcing the federal and/or state balance or surprise billing protection laws. Visit https://www.commonwealthfund.org/publications/maps-and-interactives/2022/feb/map-no-surprises-act#map for information and to view the No Surprises Act Map.

For more information about the impact of the No Surprises Act on consumers, including how to file complaints, please refer to the Centers for Medicaid and Medicaid Services' No Surprises Act Consumer FAQ page.

Visit https://www.cms.gov/nosurprises/policies-and-resources/overview-of-rules-fact-sheets for more information about your rights under federal law.

Visit https://www.ncsl.org/health/surprise-and-balance-billing-state-policy-options for more information about your rights under state law.

To contact state regulators regarding the No Surprises Act, please click here for agency websites.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

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Notes

Notes

Contacts

Medical
Blue Cross Blue Shield of Kansas City
888.989.8842
www.bluekc.com

Dental
Guardian
888.600.1600
www.guardiananytime.com

Vision
EyeMed
866.939.3633
www.eyemedvisioncare.com

Life/AD&D and Disability
Mutual of Omaha
800.877.5176
www.mutualofomaha.com

Northwest Health Services
Human Resources
hr@nwhealth-services.org

To see plan documents and view your benefits online, please visit nwhs.millercares.com.