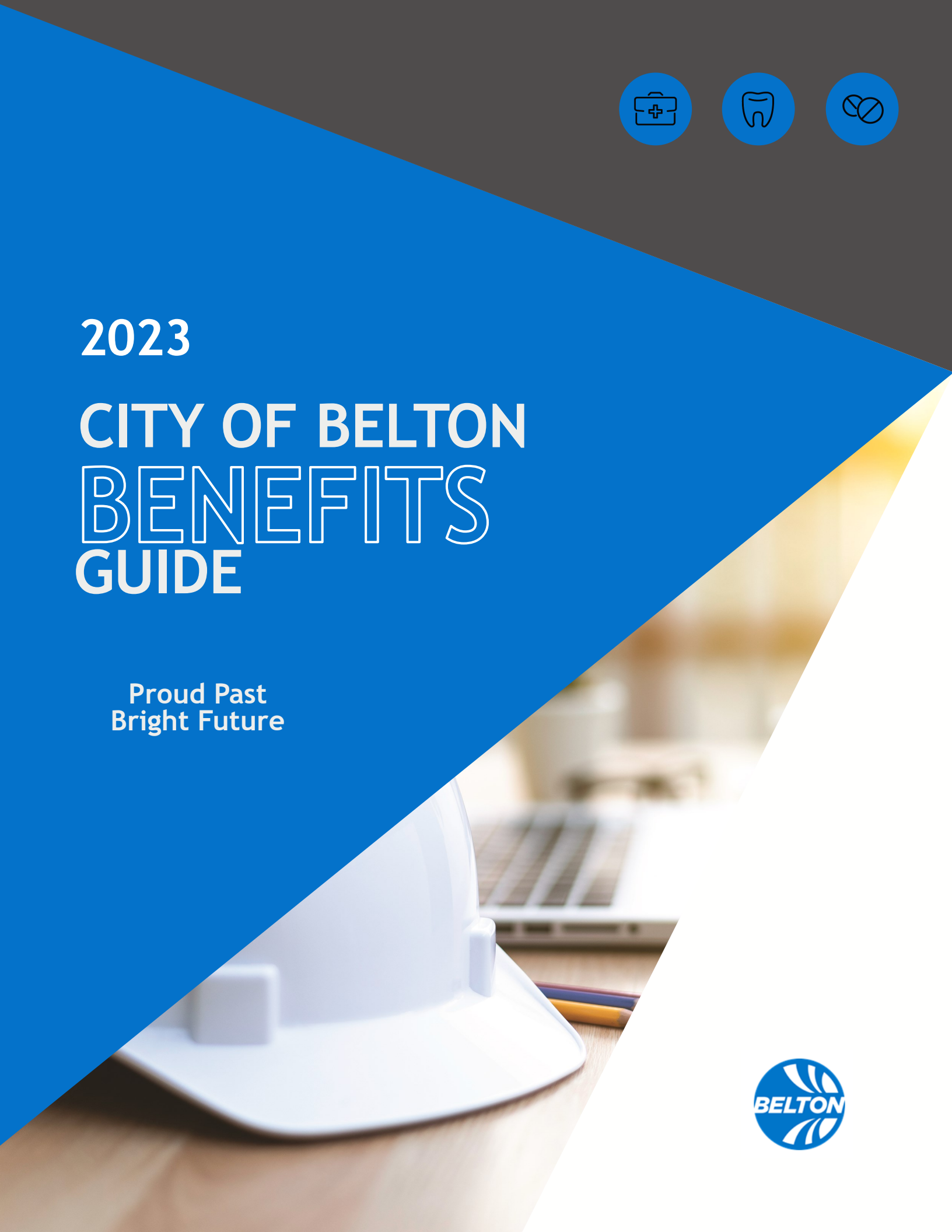
2023

CITY OF BELTON BENEFITS GUIDE

Proud Past
Bright Future



2023 BENEFITS OVERVIEW

FOR BENEFITS EFFECTIVE 1/1/2023-12/31/2023

It's that time of year again! The City's annual insurance open enrollment period is about to begin.

We know that benefits are an integral part of the overall compensation package provided to all of our eligible employees, which is why we take great care to review all available benefits options on an annual basis.

PLEASE COMPLETE CHANGES TO YOUR BENEFIT ELECTIONS ONLINE.

NOT SURE HOW TO GET STARTED? DON'T WORRY!

Now is the perfect time to prepare by doing the following:

- ✔ Check that your personal information on record is accurate
- ✔ Review the benefits in which you are currently enrolled
- ✔ Please review this benefit guide completely
- ✔ Watch videos posted to the Benefits page
- ✔ Submit any questions to employeebenefits@belton.org

In this booklet, you'll find easy-to-understand instructions to help you make your benefit decisions.

As always, we value you as a member of the City of Belton family and look forward to a healthy and safe 2023.

TIP

REMEMBER! Open enrollment is the one — and only — time of year when you can make any adjustments for the upcoming plan year, unless you have a qualifying event change.

NOTE: Details regarding The City of Belton's plans can be found in the Summary Plan Description/Summary of Benefits and Coverage documents. To request these documents, please contact the Benefits Department.

Want to learn more?

Throughout this guide, you'll find clickable video and link icons that will take you to resources that provide additional info on your available benefits.

IMPORTANT DATES

Deadline to Enroll

November 18, 2022

2023 UPDATES AT A GLANCE

- Your medical deductible and out of pocket maximum resets **January 1, 2023.**
- Eligible employees electing Employee Only coverage on the QHDHP will receive an employer contribution each month in their HSA.
- 2023 HSA contribution limits are **$3,850** for employee only and **$7,750** for a family.
- The Flexible Spending contribution limits are **$2,850** for an individual and **$5,000** for Dependent Care.
- There are no benefit or rate changes on dental and vision.
- Open enrollment is the time of year you can make any adjustments to your benefits for the coming year.;
- Throughout the year you can ONLY change your elections if you have a qualifying event change.

TABLE OF CONTENTS

CONTACT INFORMATION

If you have any questions regarding your benefits, please contact Employee Benefits or our CBIZ representatives listed below.

MEDICAL INSURANCE
Cigna
www.cigna.com
866-494-2111

DENTAL INSURANCE
Delta Dental of Missouri
www.deltadentalmo.com
800-335-8266

VISION INSURANCE
Superior
www.superiorvision.com
800-507-3800

LIFE & DISABILITY INSURANCE
USAble
www.usablelife.com
800-370-5856

HEALTH SAVINGS ACCOUNT
United Missouri Bank
www.umb.com
816-474-4472

FLEXIBLE SAVINGS ACCOUNT
Basic
www.basiconline.com/hq/
800-372-3539 ext 6270

EMPLOYEE ASSISTANCE PROGRAM
Cigna
www.cigna.com
866-494-2111

YOUR BENEFITS TEAM
The City of Belton
employeebenefits@belton.org

CBIZ REPRESENTATIVES
Allison Elliott
allison.elliott@cbiz.com

Kaye Gray
kaye.gray@cbiz.com

INSURANCE CARRIER MOBILE APPS

Cigna

Instant access to your health care data.

- ID cards. View, print or send ID card information (front and back) right from your mobile device.
- Claims. View, search and bookmark claims quickly.
- Account balances. Instantly access your deductibles, out-of-pocket maximums and health fund balances.
- Cigna Home Delivery Pharmacy. Manage your prescriptions right from your mobile device.
- Drug search. Look up drugs and compare actual costs at pharmacies nationwide.
- Provider search. Research quality and cost of in-network doctors, dentists and pharmacies.
- Medical procedure search. Look up common procedures and compare costs of providers.
- What's covered. View your plan coverage and details.
- Health incentives. Track progress toward achieving your goals and awards.
- Health wallet. Organize and manage your health information and contacts.
- Languages supported. Available in Spanish and English.

Download on the App Store

GET IT ON Google Play

Delta Dental

Understanding your Delta Dental plan is key to getting the most out of it. If you have questions about your plan, we are here to help guide you. Creating an online account is the best way to get the most out of your Delta Dental plan.

Download on the App Store

GET IT ON Google Play

Superior Vision

Why Superior Vision? Not all vision care is the same. Visit our virtual experience to learn more about the advantages of being a Superior Vision member. If you're new to Superior Vision, welcome! Click the button below to create your member portal account.

Download on the App Store

GET IT ON Google Play

QUALIFYING LIFE EVENTS

When you participate in our health plans or Flexible Spending Account, you are obligated to maintain your election through the full year.

However, certain qualifying events may occur that would allow you to add, change or terminate your election(s).

- Birth or adoption of a child
- Marriage or Divorce
- Legal Separation
- Loss of dependent status
- Change in employment status for yourself, spouse, or eligible dependent
- Gain or loss of eligibility for Medicare/ Medicaid for yourself, spouse or dependent

HOW DO I MAKE A CHANGE TO MY PLANS DURING THE YEAR?

To change any of your elections due to a qualifying event, you must notify Employee Benefits within 30 days of the event date.

If Employee Benefits is not notified within 30 days, you will not be allowed to make any changes to your elections until the annual enrollment period.

Please note that proper documentation of the qualifying event will be required.

Additionally, the change you make to your election must be consistent with and appropriate for your new circumstance.

FULL TIME EMPLOYEE BENEFIT SUMMARY

Medical Rates			
Open Access Plus QHDHP HSA	**Monthly Rate**	**Monthly City Portion**	**Monthly Employee Portion**
Employee Employee + Spouse Employee + Child(ren) Employee + Family	$775.42 $1,824.61 $1,824.61 $2,043.27	$858.12 $1,739.87 $1,739.87 $1,739.87	$0.00* $84.74 $84.74 $303.40
Open Access Plus PPO	**Monthly Rate**	**Monthly City Portion**	**Monthly Employee Portion**
Employee Employee + Spouse Employee + Child(ren) Employee + Family	$858.12 $2,017.55 $2,017.55 $2,258.25	$858.12 $1,739.87 $1,739.87 $1,739.87	$0.00 $277.68 $277.68 $518.38
Open Access Plus HMO	**Monthly Rate**	**Monthly City Portion**	**Monthly Employee Portion**
Employee Employee + Spouse Employee + Child(ren) Employee + Family	$966.50 $2,272.94 $2,272.94 $2,544.88	$858.12 $1,739.87 $1,739.87 $1,739.87	$108.38 $533.07 $533.07 $805.01

* *The city contributes $82.70 to the employee's HSA.*

- Life insurance for employee (1.5 times annual salary) through USAble – fully paid
- Dental insurance for employee and family through Delta Dental – fully paid
- Vision insurance for employee and family through Superior Vision – fully paid
- Long term disability insurance through USAble – fully paid
- Retirement plan – Missouri Local Government Employees' Retirement System – fully paid
- Employee Assistance Program through Cigna – fully paid
- Paid vacation: per city code available for use after 90 days of employment
- Paid sick leave – 96 hours earned each year for regular full time employees. 130 hours earned each year for 24-Hour fire
- Paid Holidays: 15 paid Holidays
- Deferred Compensation Plans
- Flexible Spending Account for health and dependent care expenses
- Wellness program membership partially paid by City of Belton
- Tuition reimbursement program

The City retains the right to modify the employee benefits package as necessary.

MEDICAL INSURANCE

YOUR HEALTH PLAN OPTIONS

As a full-time employee of the City of Belton, you have the choice between three medical plan options: a Qualified High Deductible (QHDHP) plan, OAP/PPO plan, or OAPIN/HMO plan. All three plans use the same network of providers - the Cigna Open Access Plus network.

For each, your deductible and/or out of pocket maximum will run from January 1–December 31.

While the QHDHP and OAP/PPO plans give you the option of using out-of-network providers, you can save money by using in network providers because CIGNA has negotiated significant discounts with them. If you choose to go out-of-network, you'll be responsible for the difference between the actual charge and the CIGNA UCR (Usual, Customary and Reasonable) charge, plus your out-of-network deductible and coinsurance.

The QHDHP option offers you lower premiums than the other two plans, and you can establish a Health Savings Account (HSA) with UMB Bank and contribute all or part of the premium savings into the HSA. These funds can be used to cover medical expenses, including deductibles, and they're yours forever—even if you leave the City of Belton. And unlike a Flexible Spending Account (FSA), they are not forfeited at the end of each year.

As a reminder, when you enroll in the OAPIN/HMO plan, you must stay in-network for all services using the Open Access Plus network. Only true emergencies will be covered at an out-of-network hospital. With the OAPIN/HMO, you must choose a Primary Care Physician for each covered member in your family. Each person may have a different PCP. Family Practice, General Practice, Internal Medicine, and Pediatricians are considered PCPs.

To look up your provider, go to www.cigna.com, click on Find a Doctor, Dentist or Facility, click on Employer or School, enter your location, click on type of provider, continue as a Guest, and finally choose "Open Access Plus, OA plus, Choice Fund OA Plus"

TIP **Get the most out of your insurance by using in-network providers.**

SELECT YOUR MEDICAL PLAN

- OPTION 1: **OPEN ACCESS PLUS QHDHP (HSA)**
- OPTION 2: **OPEN ACCESS PLUS OPA (PPO)**
- OPTION 3: **OPEN ACCESS PLUS OAPIN (HMO)**

Frequently Asked Questions

How many hours do I need to work to be eligible for insurance benefits?

You must be a full-time employee working a minimum of 30 hours per week on a regular basis.

Does the deductible run on a calendar year or policy year basis?

A calendar year basis.

How long can I cover my dependent children?

Dependent children are eligible until the end of the calendar year in which they turn age 26.

I just got hired. When will my benefits become effective?

Your medical insurance benefit will begin on the 1st of the month following 60 days of employment.

MEDICAL INSURANCE

Medical Rates and Coverage	Option 1: Open Access Plus QHDHP/HSA	Option 2: Open Access Plus OAP/PPO	Option 3: Open Access Plus OAPIN/HMO
	Employee Cost Per Month	Employee Cost Per Month	Employee Cost Per Month
Employee Employee + Spouse Employee + Child(ren) Employee + Family	$0.00* $84.74 $84.74 $303.40	$0.00 $277.68 $277.68 $518.38	$108.38 $533.07 $533.07 $805.01
	In-Network	**In-Network**	**In-Network Only**
Deductible Individual / Family	$3,000 / $6,000	$2,000 / $6,000	N/A
Coinsurance (Member Pays)	20%	20%	0%
Out-of-Pocket Maximum Individual / Family (includes deductible, coinsurance & copay)	$4,000 / $8,000	$4,900 / $13,700	$5,500 / $12,775
Physician Services Preventative Care Primary Care Physician / Specialist Diagnostic Lab / X-Ray Urgent Care	 Covered at 100% Deductible then 20% Deductible then 20% Deductible then 20%	 Covered at 100% $40 / $80 copay Covered at 100% $80 copay	 Covered at 100% $40 / $80 copay Covered at 100% $80 copay
Hospital Services Inpatient Care (Facility / Physician) Outpatient Surgery High Tech Diagnostics Ambulance Emergency Room	 Deductible then 20% Deductible then 20% Deductible then 20% Deductible then 20% Deductible then 20%	 Deductible then 20% Deductible then 20% Deductible then 20% Deductible then 20% $200 then 20%	 $750 per day[1] $750 per day Covered at 100% Covered at 100% $200 per visit
Prescription Drug Deductible Retail Tier 1 / 2 / 3 Mail Order (90-day supply)	 Applies, then: $15 / $50 / $70 2 times copays	 Does Not Apply $15 / $50 / $70 2 times copays	 Does Not Apply $15 / $50 / $70 2 times copays
	Out-of-Network	**Out-of-Network**	**Out-of-Network**
Deductible Individual / Family	$3,000 / $6,000	$4,000 / $12,000	N/A
Coinsurance (Member Pays)	50%	40%	N/A
Out-of-Pocket Maximum Individual / Family	$8,000 / $16,000	$9,800 / $27,400	N/A

[1]For first 5 days per person per calendar year (only in network hospital services capped)

CARE OPTIONS & WHEN TO USE THEM

YOUR CARE OPTIONS

While we recommend that you seek routine medical care from your primary care physician whenever possible, there are alternatives available to you. Services may vary, so it's a good idea to visit the care provider's website. Be sure to check that the facility is in-network by calling the toll-free number on the back of your medical ID card, or by visiting www.cigna.com.

PRIMARY CARE

- Routine, primary/preventive care
- Non-urgent treatment
- Chronic disease management

For routine, primary/preventive care or non-urgent treatment, we recommend going to your doctor's office. Your doctor knows you and your health history best — and already has access to your medical records. You'll also likely pay the least amount out-of-pocket.

TELEHEALTH

- Cold/flu
- Diarrhea
- Fever
- Rash
- Sinus problems

CignaTelehealth, or a "virtual visit," lets you talk to a doctor anytime, anywhere from your mobile device or computer — no appointment necessary. Cigna brings you care from the comfort and convenience of your home or wherever you are.

CONVENIENCE CARE

- Common infections (ear infections, pink eye, strep throat & bronchitis)
- Flu shots
- Pregnancy tests
- Vaccines
- Rashes
- Screenings

If you're unable to get to your doctor's office and your condition is not urgent/an emergency, these providers serve as a good alternative. They are often located in malls or retail stores (such as CVS, Walgreens, Wal-Mart and Target), and generally serve patients 18 months of age or older without an appointment. Services may be provided at a lower out-of-pocket cost than an urgent care center.

URGENT CARE

- Sprains
- Small cuts
- Strains
- Minor infections
- Sore throats
- Mild asthma attacks
- Back pain or strains

Sometimes you need medical care fast, but a trip to the emergency room may not be necessary. During office hours, you may be able to go to your doctor's office. Outside regular office hours — or if you can't be seen by your doctor immediately — you may consider going to an Urgent Care Center where you can generally be treated for many minor medical problems faster than at an emergency room.

EMERGENCY ROOM

- Heavy bleeding
- Large open wounds
- Chest pain
- Spinal injuries
- Difficulty breathing
- Major burns
- Severe head injuries

An emergency medical condition is any condition (including severe pain) that you believe may result in serious injury or death without immediate medical care. Emergency services are always considered in-network. If you receive treatment for an emergency in a non-network facility, you may be transferred to an in-network facility once your condition has been stabilized.

If you believe you are experiencing a medical emergency, go to the nearest emergency room or call 9-1-1, even if your symptoms are not described here.

Primary Care vs. Urgent Care vs. ER

CIGNA RESOURCES

First, register on myCigna.com® to activate all available programs

When your plan year begins, register on myCigna.com. That way you're ready to go whenever you need to find in-network health care providers, estimate costs or use My Health Assistant.

Register Now Using the QR Code!

Access virtual care

Conveniently connect with board-certified doctors, therapists, psychiatrists and dermatologists via video or phone.

Connect with Cigna One Guide®

Our friendly guides have forward-thinking technology to answer questions on your plan, offer personalized advice and connect you to the right care. They can also proactively reach out.

Ensure in-network care

myCigna and Cigna One Guide can help you stay in-network, maximize savings and avoid any surprises.

Get preventive care

Preventive care, such as check-ups, biometric screenings and wellness screenings, is available at no additional cost to you. It's even available4 virtually for maximum convenience.

Prioritize behavioral support

229K+ behavioral health and substance use providers can help, either in person or virtually. We also have 24/7 therapy, including Talkspace and Ginger for Cigna, and digital tools, such as iPrevail and Happify™.

Call our 24/7 Health Information Line

Talk with a clinician who can help you choose the right care, whenever you need it – late nights, holidays and more.

Simplify with mail-order medications

Express Scripts® is one of the largest pharmacies in the United States and offers convenience, savings and stress-free prescription management.

Identity Theft protection

At no additional cost.

Bounce back with Recovery-OneTM for Cigna®

Virtual physical therapy from the comfort of home is convenient and available at no additional cost to you.

Utilize case management programs

Complex medical conditions can be overwhelming. Our trained teams can help you coordinate care, understand benefits and reach goals through online coaching.

Cigna.

HEALTH SAVINGS ACCOUNT (HSA)

UNDERSTANDING A HEALTH SAVINGS ACCOUNT (HSA)

THERE ARE TWO WAYS YOU CAN PUT MONEY INTO YOUR HSA:

- Regular payroll deductions on a pre-tax basis, and
- Lump-sum contributions of any amount, anytime, up to the maximum limit.

WHAT IS AN HSA?

An HSA is exactly what it sounds like — a savings account where you can either direct pre-tax payroll deductions or deposit money to be used to pay for current or future qualified medical expenses for you and/or your dependents. Once money goes into the account, it's yours to keep — the HSA is owned by you, just like a personal checking or savings account.

YOUR HSA CAN ALSO BE AN INVESTMENT OPPORTUNITY.

Depending upon your HSA account balance, your account can grow tax-free in an investment of your choice (like an interest-bearing savings account, a money market account, a wide variety of mutual funds — or all three). Of course, your funds are always available if you need them for qualified health care expenses.

YOUR FUNDS CAN CARRY OVER AND EVEN GROW OVER TIME.

The money in your HSA always belongs to you, and we mean always. Even if you leave the company or you don't use a lot of health services now, your funds will carry over from year to year and will always be there if you need them in the future — even after retirement

HSA FUNDS CAN BE USED FOR YOUR FAMILY.

Your HSA doesn't just benefit you. You can use the funds for your spouse and tax dependents for their eligible expenses, too — even if they're not covered by your medical plan.

What Is a Health Savings Account?

Contribute up to $3,850 Single, or $7,750 Family (this includes the employer paid portion)

WHAT ARE THE RULES?

- You must be covered under a Qualified High Deductible Health Plan (QHDHP) in order to establish an HSA.
- You cannot establish an HSA if you or your spouse also have a medical FSA, unless it is a Limited Purpose FSA.
- You cannot be enrolled in Medicare or TRICARE due to age or disability.
- You cannot set up an HSA if you have insurance coverage under another plan, such as your spouse's employer, unless that secondary coverage is also a Qualified High Deductible Health Plan.
- You cannot be claimed as a dependent under someone else's tax return.

WHAT ELSE SHOULD I KNOW?

- You can invest up to the IRS's annual contribution limit. Contributions are based on a calendar year. The contribution limits for 2023 are $3,850 for Single and $7,750 for Family coverage. If you're age 55 or older, you are allowed to make an extra $1,000 contribution each year.
- The contributions grow tax-free and come out tax-free as long as you utilize the funds for approved services based on the IRS Publication 502, (medical, dental, vision expenses and over-the-counter medications, such as allergy medicine, cold and flu, pain relievers, and feminine hygiene)
- Your unused contributions roll over from year to year and can be taken with you if you leave your current job.
- If you use the money for non-qualified expenses, then the money becomes taxable and subject to a 20% excise tax penalty (like in an IRA account).
- There is no penalty for distributions following death, disability (as defined in IRC 72), or attainment of Medicare eligibility age, but taxes would apply for non-qualified distributions.
- If your health care expenses are more than your HSA balance, you need to pay the remaining cost another way. Save your receipts in case you are ever audited! You can request reimbursement later, after you have accumulated more money in your account.

HEALTH SAVINGS ACCOUNT (HSA) - CONTINUED

YOU CAN USE HSA FUNDS FOR IRS-APPROVED ITEMS SUCH AS:

- Doctor's office visits
- Dental services
- Eye exams, eyeglasses, laser surgery, contact lenses and solution
- Hearing aids
- Orthodontia, dental cleanings and fillings
- Prescription drugs and some over-the-counter medications (such as allergy medicine, cold and flu, pain relievers and feminine hygiene)
- Physical therapy, speech therapy and chiropractic expenses

More information about approved items, plus additional details about the HSA, is available at irs.gov.

IMPORTANT INFORMATION:

Every time you use your HSA, save your receipt in case the IRS asks you to prove your claim was for a qualified expense. If you use HSA funds for a non-qualified expense, you will pay tax and a penalty on those funds.

The HSA is your personal account and contains your personal funds. It can be considered an asset by a creditor and garnished as applicable.

As an HSA account holder, you will be required to file a Form 8889 with the IRS each year. This form identifies any contributions, distributions, or earned interest associated with your account.

THIS MAY BE THE BEST PLAN OPTION FOR YOU IF ANY OF THE FOLLOWING ARE TRUE:

- You do not incur a lot of medical and prescription medication expenses.
- You would like money in a savings account to pay for Qualified Expenses permitted under Federal Law.
- You would like the opportunity to contribute pre-tax income to a Health Savings Account.
- You are enrolled in the QHDHP.

FREQUENTLY ASKED QUESTIONS

WHAT WILL I PAY AT THE PHARMACY WITH THE HSA QUALIFIED PLAN OPTIONS?

You will pay the actual discounted cost of the drug until you satisfy your calendar year deductible in full.

WHAT WILL I PAY AT THE PHYSICIAN'S OFFICE WITH THE HSA QUALIFIED PLAN?

You'll provide your ID card at the time of your visit and the physician's office will submit the claim to Cigna.

You will not owe anything at the time of your visit. Later you'll receive an Explanation of Benefits (EOB) from Cigna that shows the charges discounted based on their contract with the physician. When you receive a bill from the physician's office, you pay the portion of the discounted cost you are responsible for as shown on the EOB.

WHERE CAN I GET A COPY OF AN EOB?

You can access all of your EOB information, as well as obtain other important information, by logging on to www.cigna.com.

FLEXIBLE SPENDING ACCOUNTS (FSA)

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

This account enables you to pay medical, dental, vision, and prescription drug expenses that may or may not be covered under your insurance program (or your spouse's) with pre-tax dollars. You can also pay for dependent health care, even if you choose single (vs. family) coverage. The total amount of your annual election is available to you up front, reducing your chance of incurring a large out-of-pocket expense early in the plan year. Be aware — any unused portion of the account at the end of the plan year is forfeited.

Eligible Expenses Examples

- Coinsurance and copayments
- Contraceptives
- Crutches
- Dental expenses
- Dentures
- Diagnostic expenses
- Eyeglasses, including exam fee
- Handicapped care and support
- Nutrition counseling
- Hearing devices and batteries
- Hospital bills
- Deductible amounts
- Laboratory fees
- Licensed practical nurses
- Orthodontia
- Orthopedic shoes
- Oxygen
- Prescription drugs
- Psychiatric care
- Psychologist expenses
- Routine physical
- Seeing-eye dog expenses
- Prescribed vitamin supplements (medically necessary)

HOW THE HEALTH CARE FLEXIBLE SPENDING ACCOUNT WORKS

When you have out-of-pocket expenses (such as copayments and deductibles), you can either use your FSA debit card to pay for these expenses at qualified providers or submit an FSA claim form with your receipt to Basic. Reimbursement is issued to you through direct deposit into your bank account, or by check.

2023 Maximum Contributions

Health Care Flexible Spending Account	$2,850 max
Dependent Care Expense Account	$5,000 max

Click here for the full list of Healthcare FSA Eligible Expenses

What Is A Flexible Spending Account?

What is a Dependent Care FSA?

SELECT YOUR FSA ACCOUNTS

- HEALTH CARE FLEXIBLE SPENDING ACCOUNT
- DEPENDENT CARE EXPENSE ACCOUNT

DEPENDENT CARE EXPENSE ACCOUNT

This account gives you the opportunity to redirect a portion of your annual pay on a pre-tax basis to pay for dependent care expenses. An eligible dependent is any member of your household for whom you can claim expenses on your Federal Income Tax Form 2441, "Credit for Child and Dependent Care Expenses." Children must be under age 13. Qualified care centers include dependent care centers, preschool educational institutions, and qualified individuals (as long as the caregiver is not a family member and reports income for tax purposes). Before deciding to use the Dependent Care Expense Account, it would be wise to compare its tax benefit to that of claiming a child care tax credit when filing your tax return. You may want to check with your tax advisor to determine which method is best for you and your family. Any unused portion of your account balance at the end of the plan year is forfeited.

CONTACT INFORMATION

Request a full statement of your accounts at any time by calling 800-372-3539 ext. 6270 or log on to www.basiconline.com/hq/ to review your FSA balance. The address to mail claims to is 9246 Portage Industrial Dr., Portage, MI 49024.

AT WWW.BASICONLINE.COM/HQ/, YOU CAN:

- View account information and activity
- File claims
- Manage your profile
- View notifications
- Access forms

DENTAL INSURANCE

DENTAL DENTAL OF MISSOURI

The dental plan is a PPO that offers coverage in and out-of-network. It is to your advantage to utilize a network dentist in order to achieve the greatest cost savings. If you choose to go out-of-network, you will be responsible for any cost exceeding Delta Dental's negotiated fees, plus any deductible and coinsurance associated with your procedure. Dependent children are eligible until the end of the calendar year in which they turn age 26.

MAXAdvantage: Charges for exams, cleanings, x-rays and fluoride treatments do not apply towards the annual maximum

Healthy Smiles: Patients who are pregnant, diabetic, have a suppressed immune system, or have a history of periodontal therapy are eligible to receive up to two additional cleanings each benefit year

What Is Dental Insurance?

In-Network Providers:
Provider is reimbursed based on contracted fees and cannot balance bill you.

Out-of-Network Providers:
Provider is reimbursed based on Reasonable and Customary standards and balance billing is possible.

DENTAL INSURANCE PLAN OPTIONS AND COSTS

Delta Dental of MO	Employee Cost Per Paycheck		
Employee Employee + Family	No Cost to the employee for this coverage		
	In-Network	Out-of-Network	
Deductible Individual / Family	$50 / $150		Applies to Basic & Major Services
Calendar Year Maximum	$1,250 + MAXAdvantage		Applies to Preventative, Basic & Major Services
	Carrier Pays		
Diagnostic / Preventive Services	100%	80%	■ Oral Evaluations ■ Cleanings ■ X-Rays ■ Fluoride Treatments ■ Sealants
Basic Services	80%	60%	■ Fillings ■ Endodontics ■ Periodontics ■ Simple & Surgical Extractions
Major Services	50%	40%	■ Oral surgery, except for extractions covered under Basic ■ Prosthetics: bridges and dentures ■ Crowns, jackets, veneers, inlays, onlays
Orthodontia Services (Adult and Children)	50% up to the $1,250 lifetime maximum		■ Diagnostics & Treatment

FIND A DENTAL PROVIDER

To find a Delta Dental Provider in your area, visit the website at www.deltadentalmo.com.

INSTRUCTIONS:

- Hover over **"Find a Provider" tab at the top of the page** and click on "Find a Dentist".
- Select "Delta Dental PPO" as the plan you have access to. You also have access to the Premier network, but the PPO will provide the greatest discounts.
- You can then search for dentists. You have the option to narrow your search based on your location, dentist last name, practice name, and more.

VISION INSURANCE

SUPERIOR VISION

The vision plan offers coverage both in-network and out-of-network. It is to your advantage to utilize a network provider in order to achieve the greatest cost savings. If you go out-of-network, your benefit is based on a reimbursement schedule.

In addition, if you are considering Lasik surgery or other non-covered benefits, there are discounts available with some providers. To find a participating provider, go to www.superiorvision.com.

What Is Vision Insurance?

VISION INSURANCE PLAN OPTIONS AND COSTS

SUPERIOR	Employee Cost Per Paycheck	
Employee Employee + One Employee + Family	No Cost to the employee for this coverage	
	In-Network	**Out-of-Network**
Examination Copay	$10 copay	Reimbursement Up to $34 retail
Frequency of Service (based on date of service) Exam Lenses Frames	Every 12 months Every 12 months Every 24 months	
Lenses Single Bifocal Trifocal Standard Progress Lenses	 $15 copay; 100% covered $15 copay; 100% covered $15 copay; 100% covered $15 copay; 100% covered	 Reimbursement Up to $29 retail Up to $43 retail Up to $53 retail Up to $53 retail
Frames	$15 copay; $130 allowance, 20% off balance over $130 allowance	Reimbursement Up to $65 retail
Contact lenses (instead of glasses)	$15 copay on fitting fee; $130 retail allowance	Reimbursement Up to $100 retail

Materials copay applies to lenses and frames only, not contact lenses. One copay applies to both lenses and frames.

FIND A VISION PROVIDER

To find a Superior Vision Provider in your area, visit the website at www.superiorvision.com.

INSTRUCTIONS:

- On the right side of the webpage click on “members” and then on the next page click on “Find an eye care professional”
- Enter your location, coverage type (Insurance through Employer), network (Superior National Network), and distance
- Results list providers closest to your ZIP code first
- You can then refine your search by picking your service or name then scroll through the list

LIFE INSURANCE AND AD&D

USAble Life℠

REVIEW YOUR LIFE INSURANCE POLICY

- ADD YOUR SPOUSE
- ADD YOUR DEPENDENTS
- INCREASE YOUR COVERAGE

BASIC LIFE AND AD&D

USAble Life provides 1½ times your annual earnings to a maximum of $250,000 in Basic Life and Accidental Death & Dismemberment (AD&D) insurance.

This coverage is offered through USAble at no cost to you.

What Is Life and AD&D Insurance?

VOLUNTARY LIFE AND AD&D AND DEPENDENT LIFE

You can purchase additional Life and AD&D Coverage beyond what the City of Belton provides. USAble Life guarantee issues coverage during your initial enrollment period—which means you can't be turned down for coverage based on medical history.

- **Voluntary Employee Life & AD&D:** minimum $10,000 to a maximum of 5 times your annual salary, or $500,000, in $10,000 increments. Guarantee issue up to $50,000, up to age 69.
- **Optional Spouse Life & AD&D:** minimum $5,000 up to 100% of the employee amount, to $250,000 maximum in $5,000 increments. Guarantee issue up to $10,000, up to age 69 (spouse premiums based on spouse's age)
- **Optional Child Life & AD&D:** age 6 months to 26 minimum $2,500 up to $10,000 maximum. Guarantee issue up to $10,000. Live birth to 6 months $1,000.

If you don't enroll in the Voluntary Life and AD&D plan during your initial enrollment period, you will be required to complete an Evidence of Insurability form and be approved by USAble Life before you're able to get coverage in the future.

Applying for coverage over guaranteed issue will also require Evidence of Insurability.

Please note: If you elect Voluntary Life for yourself and/or your dependents, Voluntary AD&D is an automatic election based on the voluntary life insurance amount. Employee must elect coverage in order for spouse and/or eligible dependent children to enroll.

VOLUNTARY LIFE / AD&D AND DEPENDENT LIFE OPTIONS. PREMIUMS BASED ON 12 PAYROLL DEDUCTIONS PER YEAR.

USAble	Rates per $10,000 of coverage	
	Benefit	Premium
Voluntary Life (view additional premium amounts on benefit portal)	$10,000	$2.22
	$20,000	$4.44
	$30,000	$6.66
	$40,000	$8.88
	$50,000	$11.10
	$60,000	$13.32
	$70,000	$15.54
	$80,000	$17.76
	$90,000	$19.98
	$100,000	$22.20
	$110,000	$24.42
	$120,000	$26.64
	$500,000	$111.00
	Child(ren)	$0.21/month for $2,500 coverage
Voluntary AD&D *Per $10,000*	$.030	

Important Note: The above rates are subject to change. The rates shown here are meant as an illustration for you to determine the approximate deduction you may expect to see each paycheck. Due to the rounding of rates, these deductions will vary, though differences should be slight. This is not part of an insurance policy and only the actual provisions of an issued policy control. USAble Life's policies set forth the rights and obligations of covered persons and USAble Life. Please be aware that certain limitations and exclusions apply and that benefits may reduce or terminate. If you enroll for coverage, you will be provided with a certificate of insurance. Please read your certificate carefully.

DISABILITY INSURANCE

LONG-TERM DISABILITY INSURANCE

Long-Term Disability insurance offered through USAble Life is provided at no cost to you. The plan benefit is 60% of basic monthly earnings up to a maximum of $7,000 per month. Basic earnings is the average of your gross monthly income for the year immediately prior to the onset of disability and excludes commissions, bonuses, overtime pay, shift differential pay, or any other earnings.

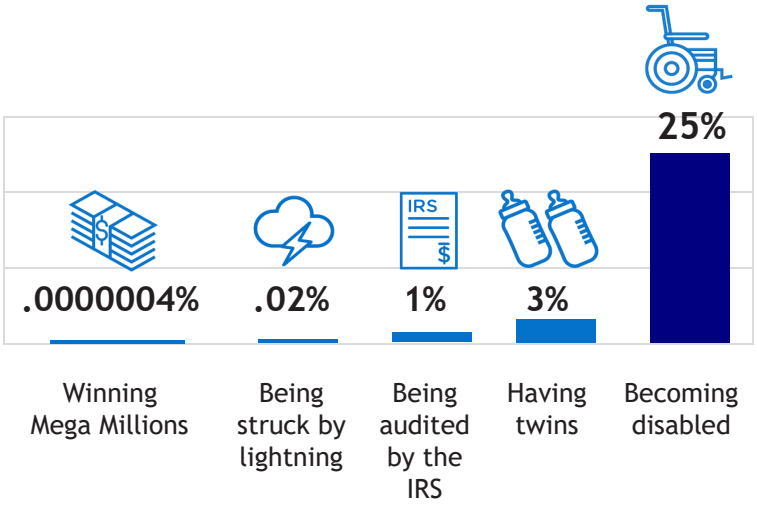
The benefits begin after a 90 day waiting period.

Covered disabilities are payable for up to 36 months if you cannot perform the duties of your own occupation. After that, you are considered disabled if you are unable to perform any occupation in which you can be expected to earn at least 60 percent of your pre-disability earnings until you reach SSNRA.

What is Long Term Disability?

WHAT'S MORE LIKELY?

Many workers think these events are more likely than becoming disabled during their careers. Here are the actual odds:



In fact, nearly **40 million** American adults live with a disability.

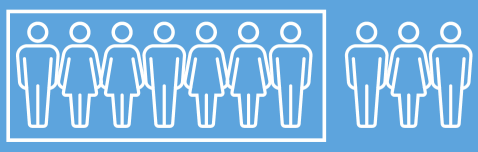
What Is Disability Insurance?

COULD YOU PAY THE BILLS IF YOU WEREN'T WORKING?

Less than **1/4** of U.S. consumers have enough emergency savings to cover six months or more of their expenses.

This benefit is 100% paid by the City.

Nearly **70%** of workers that apply for Social Security Disability Insurance **are denied.**



EMPLOYEE ASSISTANCE PROGRAM

Your well-being, productiveness and happiness depend on how well you balance your life at home and your life at work. It's difficult to be on task on the job if you're worried about problems at home; and you can't devote sufficient time to yourself and your family if you're feeling overwhelmed by work issues. This is a confidential service and The City of Belton will not be informed when this service is used.

Cigna's Employee Assistance Program is available 24 hours a day, 365 days a year to help you and your family find answers and resolve personal problems. Confidential support, guidance and resources are available to help you be happier and more productive.

This benefit is 100% paid by the City of Belton.

Assistance is available to you and immediate household family members by CALLING 866-494-2111. You can also log ONTO MYCIGNA.COM.

EAP Benefits Include:

- Up to (3) counseling sessions per occurrence
- New appointment availability search service
- Work/life support services, including consultation, resource and referral
- Services include: prevention and wellness, evidence-based interventions, behavior modification, mental health 24/7 crisis support, resilience and stress management, short-term counseling, legal and financial consultation.
- EAP Webcast portal with annual calendar of bi-monthly live webcasts
- Web-based tools and information, including self-assessments, articles, and directories

We provide work/life support to address a variety of needs at every stage of life by offering up to three qualified referrals per request. Work/life services by phone include the following:

- **Adoption** - national adoption organizations, state adoption specialists, adoption support groups, and private adoption
- **Prenatal Care** - birthing methods; nutrition, exercise, and diet; child care preplanning; and breastfeeding and formula feeding
- **Child Care** - child care centers; family child care homes; in-home care; babysitting, nanny, and au pair agencies and options; preschools/nursery schools; before- and after-school programs; and emergency backup care assistance
- **Senior Care/Caregiving** - home health agencies, nursing homes, assisted living facilities, continuing care retirement communities, social and recreational programs, long-distance caregiving, and backup and respite care
- **Pet Care** - veterinarians, pet insurance, pet sitting, obedience training, pet stores, and pet supply catalogs
- **Summer Care** - day and residential camps and traditional and specialized camp programs
- **Education** - kindergarten programs, before- and after-school programs, public schools, adult learning, scholarship and financial aid information, and undergraduate and graduate programs
- **Special Needs** - children with disabilities, developmental delays, and children who are mentally challenged/ill
- **At-Risk/High-Risk Adolescents** - transitional living programs, day and residential treatment facilities, positive after-school alternatives, and mentoring programs
- **Parenting** - child development, sibling rivalry, separation anxiety, sleep and bedtime routines, toilet training, child safety, discipline, and adolescence
- **Convenience Services** - home maintenance and repairs, recreation and leisure, event planning, travel services, automotive/transportation, personal needs, and gifts and shopping

PENSION PLAN

City of Belton

Understanding Your LAGERS Benefits

Effective 10/01/2021

STARTING YOUR CAREER

You start earning service on the first day of full time employment. Keep in mind, you must work **1,500** hours per year to be eligible.

BECOMING ELIGIBLE

Once you have worked 5 years (60 months) with any LAGERS employer, you are guaranteed to receive a benefit. Your employer fully funds your benefit. You pay 0% employee contribution.

THROUGHOUT YOUR CAREER

Your LAGERS benefit is based on your highest consecutive **36 month** average salary in the last 120 months of credited service. The more you earn, and the longer you work, the larger your retirement benefit.

READY FOR FINANCIAL INDEPENDENCE

When you reach retirement, you will reap the fruits of your labor with secure income through your retirement years.

Normal Retirement Age:

General = 60
Police = 55
Fire = 55

Early Retirement Age:

General = 55
Police = 50
Fire = 50

You may retire up to 5 years early of your Normal Retirement Age; however, your benefit is permanently reduced .5% for each month early you retire.

*See back to estimate your future benefit.

NEED A BENEFIT ESTIMATE?
LOG IN TO YOUR
myLAGERS
ACCOUNT TODAY!

Contact Us

info@molagers.org

1-800-447-4334

www.molagers.org

blog.molagers.org

Disability and Survivor Benefits

If you have worked for a LAGERS employer for more than 60 months (5 years), you are eligible for disability and survivor benefits, and if you have not worked that long, you will still be eligible if the cause of disability or death is duty-related. You can find more information about your disability and survivor benefits in the member handbook.

MISSOURI LAGERS
A Secure Retirement for All

YOUR BENEFIT AT A GLANCE:

ELIGIBILITY: 5 YEARS OF SERVICE; 1,500 HOURS ANNUALLY
PROGRAM MULTIPLIER: 2.00% (L-6)
FINAL AVERAGE SALARY: 3 YEARS
CONTRIBUTIONS: 0% EMPLOYEE CONTRIBUTION
RETIREMENT AGE: NORMAL RETIREMENT AGE

WHAT PERCENTAGE OF YOUR SALARY WILL LAGERS REPLACE?

YEARS OF SERVICE	X	BENEFIT MULTIPLIER	=	SALARY REPLACEMENT
10	X	L-6 (2.00%)	=	**20%**
15	X	L-6 (2.00%)	=	**30%**
20	X	L-6 (2.00%)	=	**40%**
25	X	L-6 (2.00%)	=	**50%**

Your LAGERS income, Social Security, and Your personal savings create a "three-legged-stool" of Retirement security that can sustain you for the rest of your life.

HOW MUCH DO I GET FROM LAGERS?

.02 (BENEFIT MULTIPLIER) X _____ (HOW LONG YOU WORK) X _____ (HOW MUCH YOU MAKE) = _____ (MONTHLY INCOME*)

Insert how many years you will have worked at your retirement age.

SERVICE TO DATE + FUTURE SERVICE (TO RETIREMENT)

Insert how much you make a month here. Note: future pay increases will increase your monthly benefit.

This is an estimate of the amount you will receive every month for life through your LAGERS benefit.

WHAT IS THE TOTAL VALUE OF MY LAGERS BENEFIT?*

_____ (MONTHLY INCOME) X **12** (# OF MONTHS IN A YEAR) X _____ (HOW MANY YEARS YOU EXPECT TO LIVE IN RETIREMENT) = _____ (ESTIMATED VALUE OF YOUR BENEFIT*)

Note: The answer will not include any cost of living adjustments (COLA's) you may receive throughout retirement

***This is designed to be an estimate of your future benefit, and it is not to be utilized as official LAGERS benefit calculation. For official caluclation, see your benefit statement or speak with a benefit specialist.**

GLOSSARY OF MEDICAL TERMS

INSURANCE TERMS

Coinsurance — The plan's share of the cost of covered services which is calculated as a percentage of the allowed amount. This percentage is applied after the deductible has been met. You pay any remaining percentage of the cost until the out-of-pocket maximum is met. Coinsurance percentages will be different between in-network and out-of-network services.

Copays — A fixed amount you pay for a covered health care service. Copays can apply to doctor's office visits as well as urgent care and emergency room services. Copays will not satisfy any part of the deductible. Copays should not apply to any preventive services.

Deductible — The amount of money you pay before services are covered. Services subject to the deductible will not be covered until it has been fully met. It does not apply to any preventive services, as required under the Affordable Care Act.

***Embedded Deductible** — The single team member deductible is *embedded* into the family deductible, meaning no one person covered under the plan can contribute more than the single amount towards the family deductible.

Lifetime Benefit Maximum — All plans are required to have an unlimited lifetime maximum.

Network Provider — A provider who has a contract with your health insurer or plan to provide services at set fees. These contracted fees are usually lower than the provider's normal fees for services.

Out-of-Pocket Maximum — The most you will pay during a set period of time before your health insurance begins to pay 100% of the allowed amount. The deductible, coinsurance and copays are included in the out-of-pocket maximum.

Preauthorization (also known as Prior Authorization (PA))— — A process conducted by your health insurer or plan to determine if any service, treatment plan, prescription drug or durable medical equipment is medically necessary. This is sometimes called

UCR (Usual, Customary and Reasonable) — The amount paid for medical services in a geographic area based on what providers in the area usually charge for the same or similar service.

MEDICAL TERMS

Prescription Drugs — Each plan offers its own unique prescription drug program. Specific copays apply to each tier and a medical plan can have one to five separate tiers. The retail pharmacy benefit offers a 30-day supply. Mail order prescriptions provide up to a 90-day supply. Sometimes the deductible must be satisfied before copays are applied.

Urgent Care — Care for an illness, injury or condition serious enough that a reasonable person would seek immediate care, but not so severe to require emergency room care.

Emergency Room — Services you receive from a hospital for any serious condition requiring immediate care.

Preventive Services — All services coded as Preventive must be covered 100% without a deductible, coinsurance or copayments.

Medically Necessary — Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, which meet accepted standards of medicine.

IMPORTANT NOTICES

MEDICARE PART D CREDITABLE COVERAGE

Important Notice from City of Belton About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Belton and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. City of Belton has determined that the prescription drug coverage offered by the Cigna health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

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

If you decide to join a Medicare drug plan, your current City of Belton overage **may** be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop the City of Belton medical plan, **be aware that you and your dependents may not be able to get this coverage back**.

IMPORTANT NOTICES

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with City of Belton and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Belton changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2023
Name of Entity/Sender:	City of Belton
Contact--Position/Office:	Benefits Department
Address:	506 Main Street, Belton, MO 64012
Email:	employeebenefits@belton.org

IMPORTANT NOTICES

Premium Assistance Under Medicaid and the Chidren'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 premiumassistance 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, 2022. Contact your State for more information on eligibility.

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & ChildHealth Plan Plus (CHP+)**
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	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecove ry.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA-Medicaid	MASSACHUSETTS-Medicaid and CHIP
GA HIPP Website: https://medicaid.georgia.gov/health- insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 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.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA-Medicaid	**MINNESOTA-Medicaid**
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	Website: 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
IOWA-Medicaid and CHIP (Hawki)	**MISSOURI-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	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS-Medicaid	**MONTANA-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY-Medicaid	**NEBRASKA-Medicaid**
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	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA-Medicaid	**NEVADA-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)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE-Medicaid	**NEW HAMPSHIRE-Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	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

IMPORTANT NOTICES

NEW JERSEY-Medicaid and CHIP	SOUTH DAKOTA-Medicaid
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: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK-Medicaid	**TEXAS-Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA-Medicaid	**VERMONT-Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA-Medicaid and CHIP	**VIRGINIA-Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone:1-800-432-5924
OREGON-Medicaid	**WASHINGTON-Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA-Medicaid	**WEST VIRGINIA-Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP- Program.aspx Phone: 1-800-692-7462	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)
RHODE ISLAND-Medicaid and CHIP	**WISCONSIN-Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA-Medicaid	**WYOMING-Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and- eligibility/ Phone: 1-800-251-1269

IMPORTANT NOTICES

To see if any other states have added a premium assistance program since July 31, 2022, 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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, anddisplays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no personshall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

This notice is a summary. For a full description of all of City of Belton benefit plans, please refer to the Summary Plan Descriptions, available from the Benefits Department.

IMPORTANT NOTICES

INITIAL COBRA NOTICE ***[FOR NEW HIRES OR NEW BENEFITS ELIGIBLE ONLY]***

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [*enter name of employer sponsoring the Plan*], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

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

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

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

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

IMPORTANT NOTICES

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

This notice is a summary. For a full description of all of City of Belton's benefit plans, please refer to the Summary Plan Descriptions, available from the Benefits Department.

IMPORTANT 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.
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: [insert deductibles and coinsurance applicable to these benefits]. If you would like more information on WHCRA benefits, call your Plan Administrator at 816-359-4021.

IMPORTANT INFORMATION REGARDING 1095 FORMS

As an employer with 50 or more full-time employees, we are required to provide 1095-C forms to each employee who was employed as a full-time employee for at least one month during the calendar year, without regard to whether they were covered by our group health plan. These employees should expect to receive their Form 1095-C in early 2023. We are also required to send a copy of your 1095-C form to the IRS.

The information reported on Form 1095-C is used in determining whether an employer owes a payment under the employer shared responsibility provisions under section 4980H. Form 1095-C is also used by you and the IRS to determine eligibility for the premium tax credit.

SPECIAL ENROLLMENT NOTICE

During the open enrollment period, eligible employees are given the opportunity to enroll themselves and dependents into our group health plans.

If you elect to decline coverage because you are covered under an individual health plan or a group health plan through your parent's or spouse's employer, you may be able to enroll yourself and your dependents in this plan if you and/or your dependents lose eligibility for that other coverage. You must request enrollment within 31 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll any new dependent within 31 days of the event.

If you or your dependents become ineligible for Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

If you or your dependents become eligible for premium assistance from Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

To request special enrollment or obtain more information, contact the Employee Benefits office (see page 3 for contact information).

This notice is a summary. For a full description of all of City of Belton's benefit plans, please refer to the Summary Plan Descriptions, available from the Benefits Department.

IMPORTANT NOTICES

NOTICE OF MATERIAL CHANGE (ALSO MATERIAL REDUCTION IN BENEFITS)

The City of Belton has amended the Medical benefit plans. This benefit guide contains a summary of the modifications that were made. It should be read in conjunction with the Summary Plan Description or Certificate of Coverage, which is available to you once it has been updated by the carriers. If you would like a copy, please submit your request to Employee Benefits office (see page 3 for contact information).

This notice is a summary. For a full description of all of City of Belton's benefit plans, please refer to the Summary Plan Descriptions, available from the Benefits Department.

YOUR NOTES

The purpose of this booklet is to describe the highlights of your benefit program. Your specific rights to benefits under the Plans are governed solely, and in every respect, by the official plan documents and insurance contracts, and not by this booklet. If there is any discrepancy between the description of the plans as described in this material and official plan documents, the language of the documents shall govern.