VILLAGE OF GERMANTOWN 2026 BENEFIT GUIDE

INSIDE THE GUIDE

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.
Please see page 40 for more details.

This brochure summarizes the benefit plans that are available to Village of Germantown eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.

WELCOME

At Village of Germantown we recognize our ultimate success depends on our talented and dedicated workforce. We understand the contribution each employee makes to our accomplishments and so our goal is to provide a comprehensive program of competitive benefits to attract and retain the best employees available. Through our benefits programs we strive to support the needs of our employees and their dependents by providing a benefit package that is easy to understand, easy to access and affordable for all our employees. This guide will help you choose the type of plan and level of coverage that is right for you.

WHAT YOU NEED TO KNOW FOR 2026

You can also view overviews of our benefit plans by accessing our website, www.germantownwi.gov/678/information-for-employees

Sincerely,

Gosia Wormsbacher

ELIGIBILITY

ELIGIBLE EMPLOYEES:

You may enroll in the Village of Germantown Employee Benefits Program if you are a full-time employee working at least 30 hours per week.

ELIGIBLE DEPENDENTS:

You may enroll the following dependents in the Village of Germantown Employee Benefits Program:

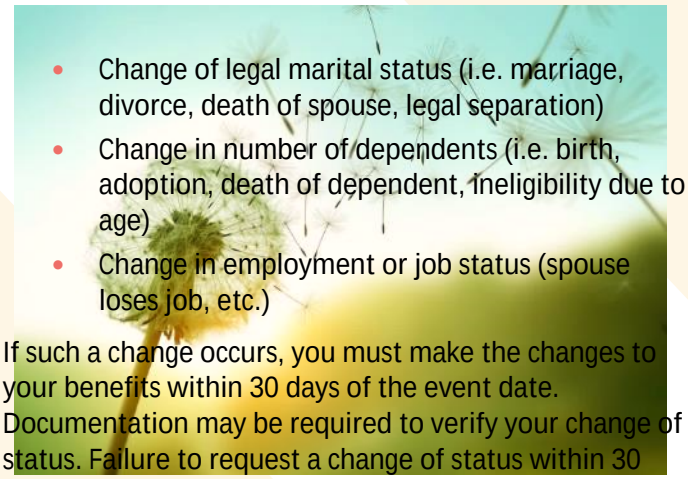
- Spouse
- Children up to age 26
- If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided
- Child(ren) under the age of 26 who is your natural child, stepchild, legally adopted child or a child obtained through court-appointed legal guardianship

WHEN COVERAGE BEGINS:

The effective date for your benefits is 01/01/2026. Newly hired employees and dependents will be effective in Village of Germantown's benefits programs immediately following date of hire. All elections are in effect for the entire plan year and can only be changed during Open Enrollment, unless you experience a family status event.

FAMILY STATUS CHANGE:

A change in family status is a change in your personal life that may impact your eligibility or dependent's eligibility for benefits. Examples of some family status changes include:



- Change of legal marital status (i.e. marriage, divorce, death of spouse, legal separation)
- Change in number of dependents (i.e. birth, adoption, death of dependent, ineligibility due to age)
- Change in employment or job status (spouse loses job, etc.)

If such a change occurs, you must make the changes to your benefits within 30 days of the event date. Documentation may be required to verify your change of status. Failure to request a change of status within 30 days of the event may result in your having to wait until the next open enrollment period to make your change. Please contact HR to make these changes.

ENROLLING IN BENEFITS

IMPORTANT REMINDERS

- Review this 2026 Benefit Guide and any additional carrier material or plan information
    - Confirm doctors and pharmacies are in-network
    - Assess your needs; discuss any changes to existing benefits with other decisions makers and dependents in your household
- Remember to keep your benefit up to date. While this can be done anytime throughout the year, Open Enrollment is a great time to review and make any changes.
- **ENROLL!** The deadline to enroll or make changes is **November 10th, 2025**.
    - Make sure your address and contact information are up to date
- **IMPORTANT!** You must enroll in your **Flexible Spending Account (FSA)** and **Dependent Care Spending Account** annually, even in a passive enrollment. These accounts do not automatically carry over. While you do not have to enroll if your **Health Savings Account (HSA)** annually, make sure you review your contributions and make any adjustments based on your needs or changes to IRS limits.

CHANGES IN BENEFIT ELECTIONS

With few exceptions, Open Enrollment is the only time of year when you can make changes to your benefits plan. All elections and changes take effect on the first day of the plan year. During Open Enrollment, you can:

- Add, change, or delete coverage
- Add, or drop dependents from coverage
- Enroll, or re-enroll in dependent or health care flexible spending accounts. To continue your FSA benefits, you must re-enroll each plan year.

MEDICAL INSURANCE: THE BASICS

AT THE DOCTOR'S OFFICE

It's recommended that you choose an in-network primary care physician (PCP) for your medical coverage, even though it is not required. A PCP can be your Family Practitioner, Internist, General Medicine, Pediatrician, or an OB/GYN (Obstetrician and Gynecologist). Each member of your family may have a different PCP.

If you are newly enrolling in medical benefits, make an appointment with your PCP- even if you're NOT sick, once the plan year has begun. This relationship will set the foundation for staying healthy—today and well into the future.

FINDING A PROVIDER OR FACILITY

You can find participating providers using UMR's online tool. Here's how:

- Go to **UMR.com** and choose the "**Find a Provider**"
- Under Network Name in the middle of the page, select "**U**" then "**UnitedHealthcare Choice Plus Network**"
- Scroll to the bottom of the page elect "**View Providers**"
- Search for "Providers and Services" and type the name of the provider you are searching for, or
- Choose the type of provider you are looking for and follow the prompts

MEMBER SERVICE PORTAL

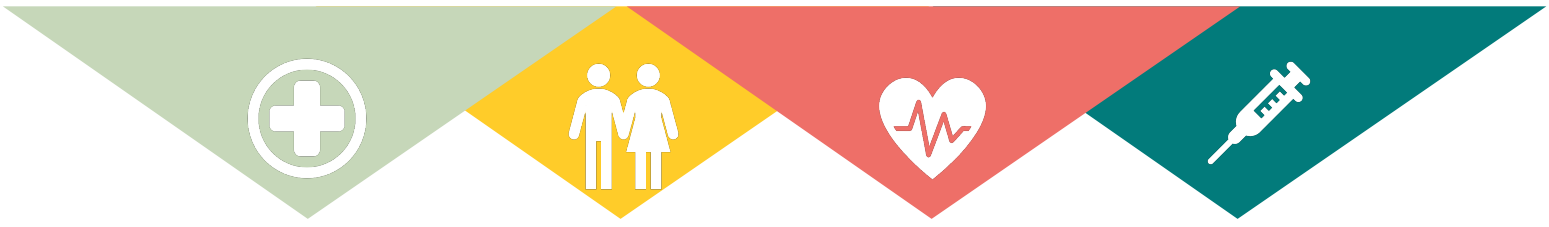
UMR's member portal is your access to secure, personalized services with interactive health tools built around you, your benefits, and your health. Access the UMR portal at www.UMR.com or download the app for helpful resources such as:

- Finding care
- Managing prescriptions
- Managing claims
- Staying healthy
- Getting coverage and cost details

PREVENTIVE CARE

Village of Germantown's Medical plan options cover Preventive Care services at 100% as long as your designated preventive care services are received from an in-network provider in an office-based, outpatient, or urgent care setting. Preventive care is routine health care that includes screenings, checkups and patient counseling to help prevent illnesses, disease or other health problems. There may be some exceptions, so it's important to know what qualities as preventive care and what questions to ask your doctor to avoid extra costs.

For a list of covered preventive care services go to www.UMR.com



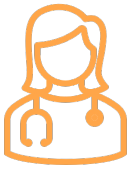
Routine physicals (age 18+) or pediatric exams (birth to age 17)

Age & gender appropriate screenings

Blood pressure screening for adults and children

Immunizations for adults and children

OPTIONS FOR CARE

				
Virtual Visits Telemedicine	**Primary Care Physician**	**Convenience Care Clinic**	**Urgent Care**	**Emergency Room**
$	$$	$$	$$$	$$$$
Convenient **Treats common, non-urgent health concerns** **Many available 24/7**	**Preventive and routine care** **Treats wide range of health issues** **Limited Hours**	**Walk-in care for minor health conditions when PCP is closed or unavailable** **May be open nights & weekends**	**Treatment of non-life-threatening injuries or illnesses** **Generally open nights & weekends**	**Immediate treatment for serious, life-threatening conditions or call 911**
• Allergies • Bronchitis • Eye infections • Cough/sore throat • Flu • Stomachache • Insect bites • Rashes	• Check-ups • Immunizations • Preventive Services • General health management • Management of chronic conditions	• Strep throat • Flu shot and some immunizations • Pregnancy tests • Minor cuts and burns	• Sprains and strains • Minor accidents, falls • Minor sprains, fractures • Minor broken bones • Minor cuts, burns	• Chest pain • Difficulty breathing • Major broken bones • Head injuries • Heavy bleeding • Seizures • Spinal injuries • Large open wounds

BENEFITS KEY TERMS EXPLAINED

Copay	Flat dollar amount member is responsible for at the time of service. The plan usually pays 100% of the remaining balance.
Deductible	Amount member is responsible for before the plan pays for certain services.
Coinsurance	Coinsurance refers to the percentage of costs shared between you and the health plan for certain services, once your deductible has been met. The table on the next page outlines the portion of coinsurance you, as the member, are responsible for.
Out-of-Pocket Maximum	Member total payments for deductible, coinsurance and copays to stated maximum per plan year. Once reached, the plan will pay 100% for eligible expenses for the rest of the plan year.
High Deductible Health Plan (HDHP)	Qualified plan as defined by the IRS. No first dollar benefits, all services are subject to the deductible before the plan will pay. Exception is Routine Preventive Care as defined by the IRS.
HSA – Health Savings Account	Tax Free account that is established by the employee that is covered by a High Deductible Health Plan (HDHP).
Network Provider	Medical and pharmacy providers that have contracted with the plan to provide lower out-of-pocket costs for members.
Premium	The amount you pay for your health insurance every month

MEDICAL

The Village of Germantown offers medical coverage. The charts above are a brief outline of what is offered. Please refer to the summary plan description for complete plan details.

MEDICAL COMPARISON

Benefit	UMR Gold Plan		UMR Silver Plan	
Networks	**United Healthcare Choice Plus**		**United Healthcare Choice Plus**	
Deductibles	$1,000 / $2,000	$1,250 / $2,500	$3,000 / $6,000	$6,000 / $12,000
Embedded or Aggregate	Embedded	Embedded	Aggreage	Aggregate
Coinsurance	10%	30%	0%	30%
Out of Pocket Maximum	$5,000 / $10,000	$10,000 / $20,000	$3,000 / $6,000	$12,000 / $24,000
Preventative Care / Teladoc Visits	Fully Covered	30% after deductible	Fully Covered	30% after deductible
Primary Office Visit Co-pay	$30 copay per visit after deductible	30% after deductible	0% after deductible	30% after deductible
Specialty Office Visit Co-pay	$45 copay per visit after deductible	30% after deductible	0% after deductible	30% after deductible
Urgent Care	$75 copay	30% after deductible	0% after deductible	30% after deductible
Emergency Room Facility Charges*	$300 copay; (waived if admitted)	$300 copay; (waived if admitted)	0% after deductible (waived if admitted)	30% after deductible (waived if admitted)
Diagnostic Tests and Imaging				
X-ray and Lab Tests	10% after deductible	30% after deductible	0% after deductible	30% after deductible
Complex Radiology	10% after deductible	30% after deductible	0% after deductible	30% after deductible
Inpatient Facility Charges	10% after deductible	30% after deductible	0% after deductible	30% after deductible
Prescription Drug Coverage				
Generic (Tier 1)	$15 copay	$15 copay	0% after deductible	30% after deductible
Preferred (Tier 2)	$45 copay	$45 copay	0% after deductible	30% after deductible
Non-Preferred (Tier 3)	$90 copay	$90 copay	0% after deductible	30% after deductible
Preferred Specialty (Tier 4)	20% cost up to $150 maximum	20% cost up to $150 maximum	0% after deductible	30% after deductible
Generic (Tier 1)	$30 copay	$30 copay	0% after deductible	Not covered
Preferred (Tier 2)	$90 copay	$90 copay	0% after deductible	Not covered
Non-Preferred (Tier 3)	$180 copay	$180 copay	0% after deductible	Not covered
Preferred Specialty (Tier 4)	20% cost up to $150 maximum	20% cost up to $150 maximum	Not covered	Not covered

Employee Contributions (Per Pay Cycle)				
Single Coverage	**Gold Plan**		**Silver Plan**	
2026 Cost Sharing	Employee pays 12% getting to Silver status	Employee pays 25% not getting to Silver status	Employee pays 12% getting to Silver status	Employee pays 25% not getting to Silver status
Monthly Premium	$1,052.66	$1,052.66	$900.22	$900.22
Village Monthly Share	$926.34	$789.50	$792.19	$675.17
Employee Monthly Share	$126.32	$263.17	$108.03	$225.06
Pay Period Deduction Amount	**$63.16**	**$131.58**	**$54.01**	**$112.53**
Family Coverage	**Gold Plan**		**Silver Plan**	
2026 Cost Sharing	Employee pays 12% getting to Silver status	Employee pays 25% not getting to Silver status	Employee pays 12% getting to Silver status	Employee pays 25% not getting to Silver status
Monthly Premium	$2,525.56	$2,525.56	$2,160.94	$2,160.94
Village Monthly Share	$2,222.49	$1,894.17	$1,901.63	$1,620.71
Employee Monthly Share	$303.07	$631.39	$259.31	$540.23
Pay Period Deduction Amount	**$151.53**	**$315.70**	**$129.66**	**$270.12**

TELEMEDICINE

With Teladoc, you can see a board-certified doctor or behavioral health specialist via secure online video from the Teladoc app or your computer. Teladoc's doctors can diagnose symptoms, prescribe nonnarcotic medication (if needed) and send prescriptions to your local pharmacy. Teladoc is a good care option for minor health problems when you can't see your regular doctor. It's also a convenient choice when you want to speak to a counselor or therapist. Below, you'll find answers to questions you may have about this benefit.

GETTING STARTED

What kind of medical care does Teladoc provide?

When requesting a consultation, you can choose between general medical, behavioral health or dermatology.

Does this replace my primary care doctor?

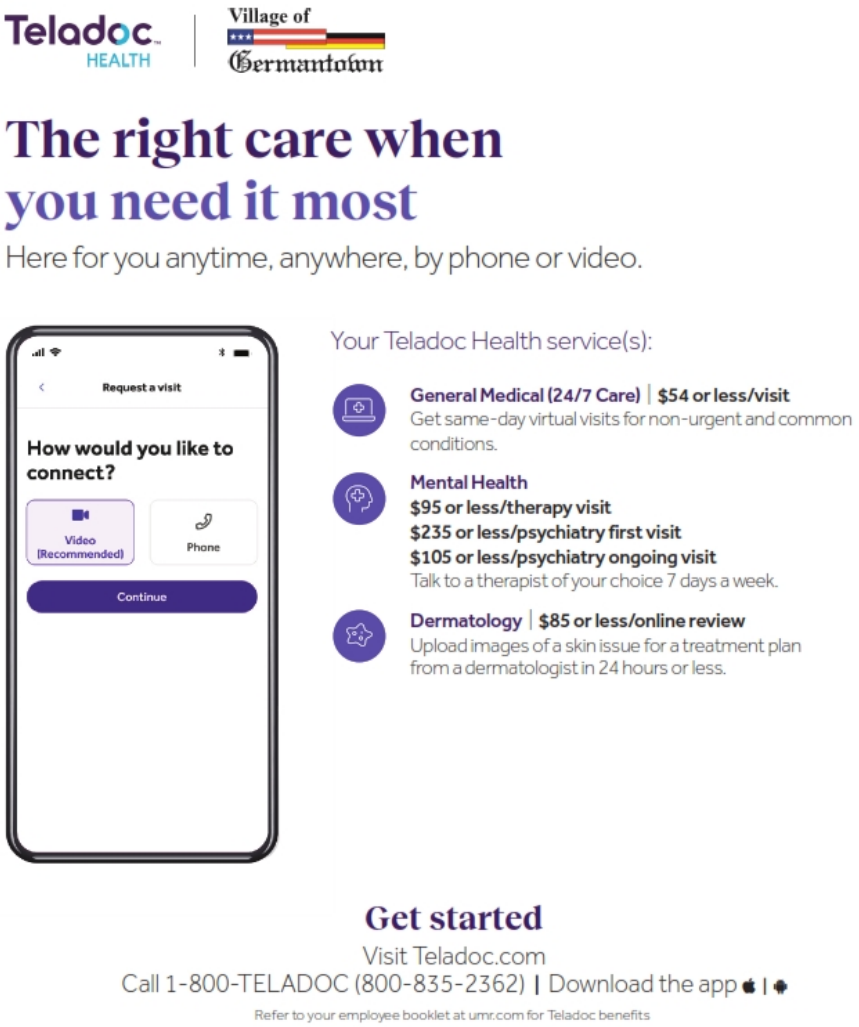
Teladoc is a convenient alternative to your doctor for non-emergency conditions. In fact, we encourage you to list your primary care doctor when activating your Teladoc account. That way, you can share the results of your video consult with them – and your medical records stay up to date.

Can Teladoc doctors write a prescription?

Yes, Teladoc doctors can prescribe short-term medications for a wide range of conditions when medically appropriate. Teladoc doctors do NOT prescribe substances controlled by the DEA, non-therapeutic and/or certain other drugs, which may be harmful because of potential abuse.

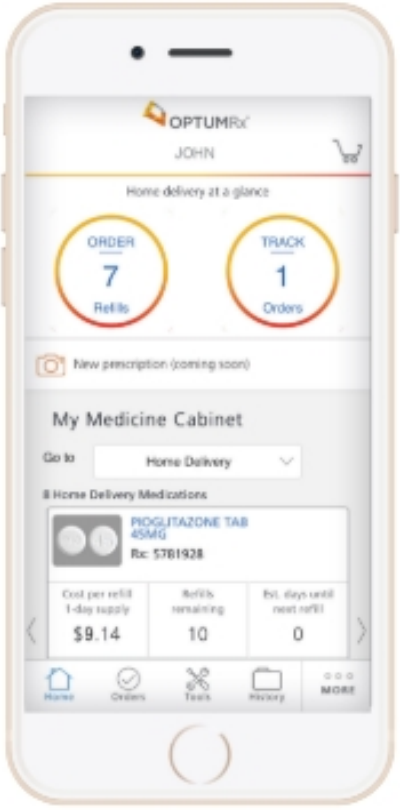
Is it private and secure?

Absolutely. Teladoc complies with the Health Insurance Portability and Accountability Act (HIPAA). It uses secure video through your computer, tablet or the Teladoc mobile app. Your personal health information is never shared with your employer.



OPTUMRx®

OptumRx app



The OptumRx app makes the online pharmacy experience as simple as possible. You can easily:

- Search drug prices at multiple pharmacies
- Locate a network pharmacy
- Manage medication reminders
- Access your ID card if your plan allows

Manage home delivery orders

- Transfer a prescription to home delivery
- Track your order
- Refill a prescription

Download the OptumRx app now
from the Apple® App Store or Google Play™.

Download on the App Store

GET IT ON Google play

The OptumRx app: the most convenient way to manage your prescriptions.

Simple

Refill a medication or transfer a retail prescription to home delivery.

Current

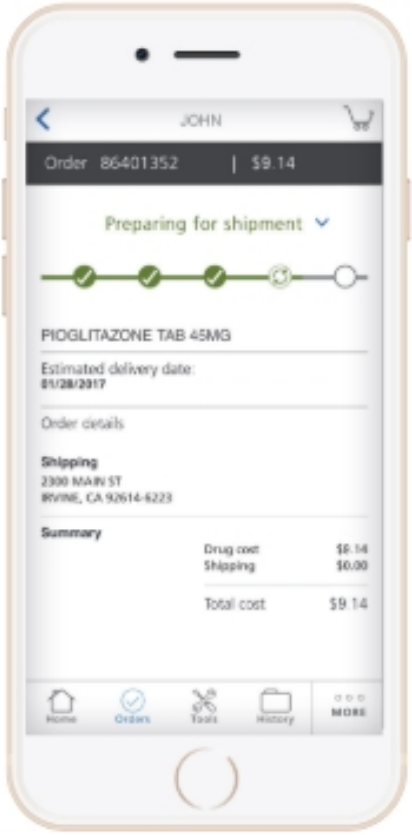
The OptumRx app gives you quick access to your plan's most current drug coverage information.

Personalized

Access a complete profile of your prescriptions when you view My Medicine Cabinet. You can see all your recent and past prescriptions.

Save time and money

Compare prescription drug options and identify potential cost savings.



FAMILY REIMBURSEMENT ACCOUNT (FRA) IN LIEU OF MEDICAL COVERAGE

***You are only eligible for this plan if you are <u>currently</u> enrolled in the Village of Germantown's medical plan as of 10/1/25 or hired after 10/1/25.**

WHAT IS A FAMILY REIMBURSEMENT ACCOUNT (FRA)?

A family reimbursement account offers you and your family reimbursement for incurred medical expenses if you choose to enroll in your spouse's or parent's medial plan instead of Village of Germantown's medical plan.

HOW IT WORKS:

Any in-network medical or prescription expenses you incur through the other group coverage will be paid for by the Village up to the Family Reimbursement Account IRS maximum benefit. Please note, if the other group coverage is an HSA compliant High-Deductible medical plan, 2026 IRS rules dictate that you will be responsible for the first $1,700 in expenses on a single plan and $3,400 on a family plan, before the Family Reimbursement Account can begin to reimburse for claims. This is done to ensure that the plan that you are enrolling in maintains HSA qualified HDHP status because if it doesn't, you could incur tax penalties. If you have HSA funds available, you can use those to pay the $1,700 or $3,400 before the FRA kicks in.

Employees that are enrolled in the Village's medical plan as of 10/1/25 or hired after 10/1/25 are eligible for a $25 per member per month taxable benefit and the Family Reimbursement Account (FRA). Members that waive the Village's medical plan as of 10/1/25 are eligible for a $50/month taxable benefit.

ELIGIBLE EMPLOYEES:

You may enroll in the Village of Germantown's Family Reimbursement Account Program if you are a full-time employee must be working an average of 30 hours or more per week and waive coverage on or after 2026.

MID-YEAR PLAN CHANGES:

Contact Gosia for eligibility change options.

THINGS TO CONSIDER PRIOR TO OPEN ENROLLMENT:

Would you consider cancelling the Village of Germantown's medical coverage effective January 1st during the Village's open enrollment? Or cancelling at the time of your spouse's or parent's open enrollment?

And have you verified with the other group coverage (either through your spouse's or parent's employer) that enrollment on their medical plan is possible, coinciding with the effective date of the FRA?

REIMBURSEMENT OF OUT-OF-POCKET MEDICAL EXPENSES:

The district will pay 100%* of your in-network deductibles, coinsurance, copays, and prescription drug expenses incurred on the alternate health plan.

*IRS special rules to consider if the alternate health plan is an HSA qualified high-deductible health plan (HDHP).

FREQUENTLY ASKED QUESTIONS:

How will I receive reimbursements?

- Reimbursements will be dispersed through DBS.

Will my reimbursements be taxed?

- No, your reimbursement is not considered taxable income.

What if my spouse or parent's plan is a High-Deductible Health Plan (HDHP)?

- IRS rules dictate that you will be responsible for the first $1,700 in expenses on a single plan and $3,400 on a family plan before the Family Reimbursement Account can begin to reimburse you for claims. This is done to ensure that the plan you are enrolling in maintains HSA qualified HDHP status. Otherwise, you would incur tax penalties.

WELLNESS INITIATIVES

Whether your goal is to have more energy, lose weight, manage stress, or improve your diet, Village of Germantown Wellness program can help you. We consider Wellness to be a vital part of our overall benefits program. As healthcare costs continue to rise, we strive to offer competitive health benefits to take care of you and your family. A successful wellness program is a win-win — it means our employees are improving their lives, and we are one step closer to managing rising health insurance costs.

Vitality®
Let's Get Started!

Be a Goal-Getter!

Get Started with the Power of

A comprehensive, interactive, and personalized wellness program that makes it easy for you to make healthy choices.

- Visit the Power of Vitality website and/or download the Power of Vitality mobile app (Apple App Store, Android Google Play)
- Select **"register now"** *(eligible the first day of your program year)*. Follow the prompts on the screen which will navigate you through username, password, security questions, etc.
- **Earn your first 75 points** by answering a two-question onboarding survey that will start customizing the program to you.

Earn Points, Increase Your Status, Earn Rewards

Vitality provides a range of tools and resources to navigate your way to a healthier you! As you earn more points, you will increase your status level, and earn greater rewards.

- **Health Assessment** (500 points) and micro-assessments (75 points) – questionnaires that customize the program to you
- **Preventative Screenings**, such as Dentist (200 points), Cancer (400 points), Vaccinations (200 points), Biometrics (BMI, Blood Pressure, Cholesterol, Glucose – earn up 3,300 points)
- **Goal Setting** (up to 15 points a day) – select topics important to you and check-in daily
- **Focus Areas** – based on your data through screenings, questionnaires, and interaction with Vitality, groups of different activities will be recommended specifically for you!

BRONZE	SILVER	GOLD	PLATINUM
0 pts	2,500 pts	6,000 pts	10,000 pts

Sync a Device to Earn Daily Points for Activity

How to Connect: on the Power of Vitality Website and/or on your mobile app, click on the profile icon (settings), select Apps and Devices, select the device or app you would like to connect (ie: Apple, Garmin, Fitbit, Google Fit), then follow the prompts on the screen.

Share Activity Data with Vitality to maximize your point earning opportunities.

Workouts:
Light (5pts): 5,000 steps, 100 calorie burn, or 15 min at 60% Max HR
Standard (10 pts): 10,000 steps, 200 calorie burn, or 30 min at 60% Max HR
Advanced (15 pts): 15,000 steps, 300 calorie burn, or 45 min at 60% Max HR
Other (points vary): Gym Check-in, Self-Reported Workouts, Active Calorie Burn

No fitness device? No problem.
Connect your Apple or Samsung Health app. Your phone tracks your steps if it on you even without a fitness device.

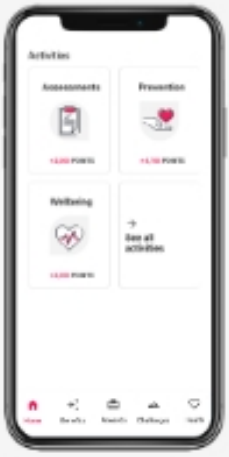
Scan to download or open the Power of Vitality mobile app

Contact wellness@powerofvitality.com or 877.224.7117 (8am-5pm CST, Mon-Fri)

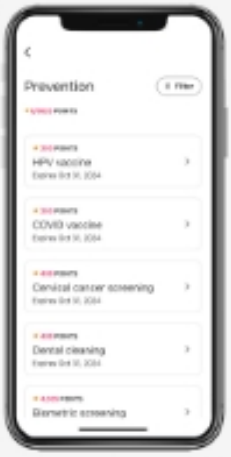
Be positively proactive with prevention

Managing your health with preventive services and good lifestyle habits is key to living healthier and preventing disease. Here's how you can get started!

1 Log into the Power of Vitality website or mobile app

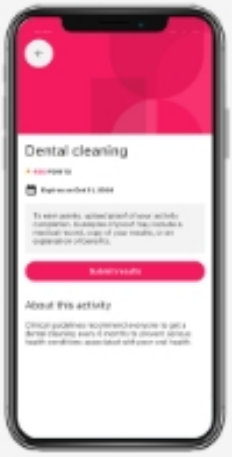


2 Scroll down to ACTIVITIES and select PREVENTION



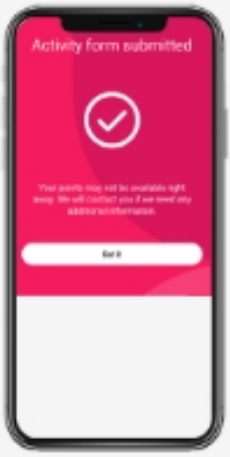
3 Choose your prevention activity from the list*

PLEASE NOTE: *Members' sets of recommended prevention activities will differ based on sex, age, health history and history of prevention activities.*

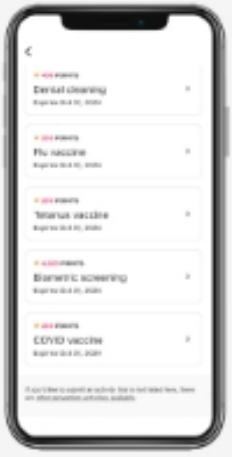


4 Fill in details about your prevention activity

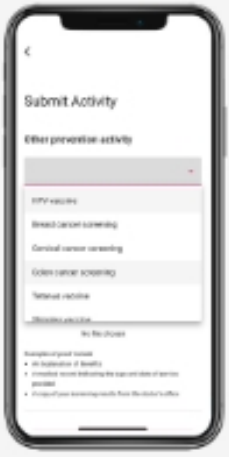
5 Tap on SUBMIT RESULTS



6 Your form has been submitted! Points will be awarded if the proof meets the criteria.



7 If you would like to submit an activity that is not listed for you under PREVENTION, scroll down to the bottom of the page and tap on OTHER PREVENTION ACTIVITIES AVAILABLE



8 Select the prevention activity

9 Fill in details about your prevention activity.

PLEASE NOTE: *Other prevention activities may require different proof, please take note of the information required before submitting to Power of Vitality.*

Scan to download the Power of Vitality mobile app

QUESTIONS? Contact us for more information or 877.224.7117 or wellness@powerofvitality.

Vitality

DENTAL

Regular dental checkups can help find early warning signs of certain health problems, which means you can get the care you need to be healthy.

Village of Germantown offers a dental plan through Delta Dental Insurance Company for all employees. With the dental plan you also have the ability to obtain dental care services from the dentist of your choice (contracted or not). The dental plan provides a higher level of benefit if you choose to use an in-network provider. For more information about your plan or to find a provider, visit www.deltadentalwi.com or call 800-236-3712. Please refer to the summary plan description for complete plan details.

Please refer to the summary plan description for complete plan details.

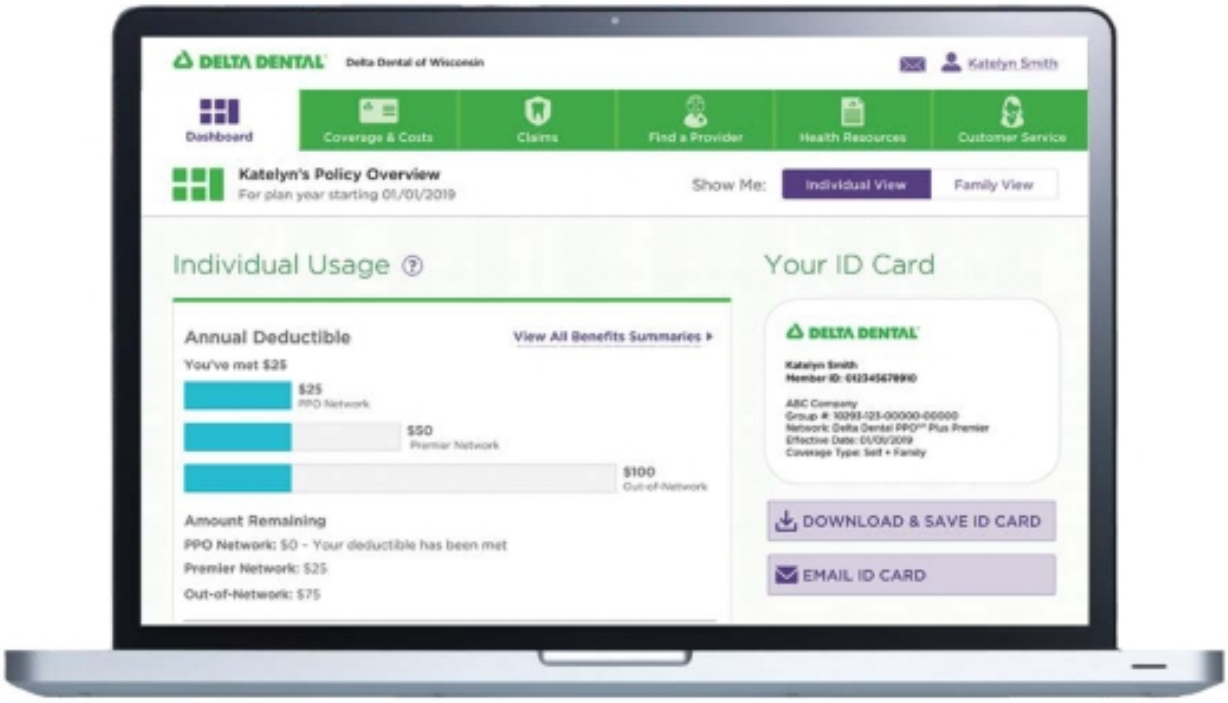
Dental Service	PPO Benefit	Non-Contracted Benefit
	In-Network Benefits	Out of Network Benefits
Annual Deductible Individual/family	$25 Individual / $75 Family	$25 Individual / $75 Family
Waived for preventive care	Yes	Yes
Annual Maximum	$1,300	$1,300
Diagnostic and Preventive Services	100%	80%
Basic Restorative Services	80%	50%
Endodontic Services	50%	40%
Periodontic Services	50%	40%
Oral Surgery Services	50%	40%
Major Restorative Services	50%	40%
Prosthetic Services	50%	40%
Orthodontic Services	50% (Lifetime Max $1,000/member)	40% (Lifetime Max $1,000/member)
Orthodontic Coverage for Dependents	Covered to age 19	Covered to age 19

DELTA DENTAL

Delta Dental Member Portal

You might not think you need to download a dental insurance ID card at 4 in the morning ... until you do. That's why we've added a number of great features and enhancements into our new member portal.

The Delta Dental member portal lets you communicate with us at a time that works for you, through whatever channel is most convenient.



What's New?

What's been added to the online member portal?

- **A revised dashboard** with at-a-glance summaries of benefits, claims, EOBs, and more.
- A **downloadable ID card** means you'll always have your card at your fingertips.
- **Secure messaging**, in case you have to talk with us about benefits, claims, or treatments.
- A **cost estimator tool** that lets you see the range of costs for a procedure in your geographic area, and helps show why it pays to go with a PPO™ provider.

Additional Features

- Simplified navigation
- Personalized oral health content
- Communication preferences
- Multi-channel support
- 24/7 access to Delta Dental benefit information
- Quick links for oral health information

Logging In

Sign In or Register at **www.deltadentalwi.com**.

VISION

Eye exams aren't just for testing your vision. Eye doctors can detect problems in overall eye health and signs of other health conditions like diabetic eye disease, high blood pressure and high cholesterol. By seeing a preferred provider, you have the benefit of a low co-payment for a vision exam and materials. For more information about your plan or to find a provider, visit www.metlife.com or call 1-800-638-5433.

	MetLife Vision	
	In-Network Benefits	Out-of-Network Benefits
What is Covered		
Deductible	None	None
Exam with dilation as necessary	$15 copay (twice/year for children)	$45
Retinal imaging copay	$39 copay	Applied to exam allowance
Frames / Lenses Copay	$0 copay; $150 allowance, 20% off balance over $150	$70
Lenses benefit frequency – based on calendar year	12 months	12 months
Frames benefit frequency – based on calendar year	24 months (adult) 12 month (child)	24 months (adult) 12 month (child)
Eyeglasses		
Single Vision	$25 copay	Reimbursed up to $30
Bifocal	$25 copay	Reimbursed up to $50
Lens Upgrades		
Progressive lenses	Standard: $0 copay Premium: $95up to $70 copay Ultra: Up to $80 copay Ultimate: Up to $175 copay	Reimbursed up to $50
Contact Lenses – covered only in lieu of eyeglasses lenses		
Conventional contacts	$0 copay; $150 allowance; 15% off balance over $150	$105 allowance
Disposable contacts	$0 copay; $150 allowance; 10% off balance over $150	$105 allowance
Medically necessary contacts	$0 copay; paid in full	$210
Contact lens fit and follow-up	Standard: $30 copay Speciality: $50 allowance after $30 copay	Not covered

Vision Monthly Premiums		
	Active Employee	**Retiree**
Employee	$4.72	$4.72
Employee + Spouse	$9.40	$9.40
Employee + Child(ren)	$10.60	$9.40
Family	$16.94	$11.04

INCOME CONTINUATION INSURANCE

WHAT IS INCOME CONTINUATION INSURANCE?

The Village covers long-term income protection through WRS in the event you become unable to work due to a non-work-related illness or injury. This benefit covers 75% of your monthly base salary up to $10,000 per month. Benefit payments begin after 30 days of disability.

It is important that you sign up for this coverage once you are eligible, otherwise you will need to complete a medical questionnaire.

HOW TO FILE A CLAIM

1. File your claim as soon as possible after your last day worked
    a. You may file a claim up to 30 days before your anticipated last day worked in cases of impending childbirth or scheduled surgery.
    b. A claim will not be approved if received more than 12 months after your last day in pay status.
    c. The effective date of your benefit can be no earlier than 90 days before your claim is filed. If you wait, you could miss out on some benefits.
2. The plan administrator will send you an introductory packet. Complete and return the medical release form and the repayment agreement.
3. A licensed physician will be required to submit medical information concerning your disability to the plan administrator.
    a. A licensed physician includes a medical doctor, doctor of osteopathy, surgeon, podiatrist, dentist, or nurse practitioner licenses to practice by a state within the United States. This also includes a physician's assistant or psychologist who is acting within the lawful scope of his or her license and performs a service that is supervised by a licensed medical doctor, doctor of osteopathy, or surgeon.
    b. For a short-term disability, a physician must certify that you are not able to perform the duties of your position.
    c. For a long-term disability, a physician must certify that you are not able to engage in any substantial gainful activity for which you are reasonable qualified, with due regard to your education, training, and experience.
4. The plan administrator will periodically contact your physician to receive updated information on your disability and expected return-to-work date. You will be responsible for costs associated with the medical exams.
5. Your employer must complete the employment statement that comes from the plan administrator
6. After contacting your physician and employer, the plan administrator will determine whether you should be approved for the benefit.

If you are approved, you will receive a letter from the plan administrator describing how much your benefit will be and when it will start. If you are denied, you will receive a letter from the plan administrator stating the reasons for the denial.

LIFE INSURANCE

BASIC COVERAGE

Continues at 100% until age 65. Premiums are deducted from monthly annuity until age 65. At age 65 premiums end and coverage continues, free for the retiree's lifetime, at reduced amounts. If interested fill out the Evidence of Insurability form which can be found on https://www.germantownwi.gov/753/11408/Life-Insurance.

SUPPLEMENTAL AND ADDITIONAL LIFE INSURANCE

Continues at 100% until age 65 and then coverage ends.

SPOUSE AND DEPENDENTS

Coverage ends at retirement.

Spouse and Child Term Life	
Option 1	$1.75
Option 2	$3.50

Basic, Supplemental, and Additional Term Life (Rate/$1,000/month)	
Age	**Active Employee**
Under 30	$0.05
30-34	$0.06
35-39	$0.07
40-44	$0.08
45-49	$0.12
50-54	$0.22
55-59	$0.39
60-64	$0.49
65-69	$0.57

ACCIDENT INSURANCE

Accident Insurance provided through Securian provides a lump-sum cash payment after an accident to help with expenses such as copays, deductibles or everyday living expenses. Accident Insurance includes coverage for concussions, fractures, dislocations, lacerations, emergency room treatment, x-rays, hospitalization, surgeries, follow-up care, support care, accident death & dismemberment (up to $100,000), identity theft, and travel assistance. Provides a lump-sum cash payment after an accident to help with expenses such as copays, deductibles or everyday living expenses.

Accident Monthly Premiums	
	Active Employee
Employee	$3.72
Employee + Spouse	$5.32
Employee + Child(ren)	$7.16
Family	$10.46

Cash payment in the event of a covered injury.

Injuries

Benefit	
Burns (2nd degree)	
Less than 10% of body	$200
Between 10 and 20% of body	$500
20% or more of body	$1,000
Burns (3rd degree)	
Less than 10% of body	$2,000
Between 10 and 20% of body	$5,000
20% or more of body	$10,000
Child organized sports injury	$200
Concussion	$300
Dislocation (surgical)	
Hip/thigh	$4,000
Knee	$2,000
Foot	$1,600
Ankle	$1,600
Hand	$800
Wrist	$1,200
Lower jaw	$800
Shoulder	$800
Collarbone	$800
Ribs	$800
Elbow	$800
Finger	$200
Toe	$200
Non-surgical (% of surgical benefit)	50%
Partial (% of non-surgical benefit)	25%
Eye injury	
With surgery	$300
Removal of foreign object	$75
Fracture (surgical)	
Skull – depressed	$6,000
Hip/thigh	$4,000
Skull – non-depressed	$4,000
Pelvis	$3,000
Sternum	$3,000
Vertebral body	$2,000

Injuries

Benefit	
Fracture (surgical)	
Lower leg	$2,000
Shoulder blade	$2,000
Upper arm	$1,400
Facial excluding lower jaw	$1,400
Foot	$1,000
Ankle	$1,000
Kneecap	$1,000
Forearm	$1,000
Hand or wrist (except fingers)	$1,000
Lower jaw	$1,000
Ribs	$1,000
Vertebral processes	$800
Collarbone	$600
Coccyx	$400
Finger	$200
Toe	$200
Nose	$200
Non-Surgical (% of surgical benefit)	50%
Chip (% of non-surgical benefit)	25%
Lacerations	
With stitches or staples	$200
Without stitches or staples	$50
Paralysis	
Quadriplegia	$10,000
Paraplegia	$5,000
Hemiplegia	$5,000
Uniplegia	$2,500

Emergency care

Benefit	
Ambulance	
Ground or water	$250
Air	$750
Blood, plasma or platelets transfusion	$300
Emergency dental	
Crown	$200
Extraction	$100
Emergency room treatment	$150
Initial physician's office visit	$75

Hospital care

Coma	$10,000	
Diagnostic testing	$100	
X-ray	$100	
Hospital stay	Non-ICU	ICU
Initial benefit	$1,000	$1,000
Daily benefit	$200	$400

Accidental death and dismemberment*

Employee	$100,000
Spouse	$50,000
Child(ren)	$25,000

Surgery

Benefit	
Abdominal, pelvic	$750
Cranial	$750
Knee cartilage	
Open	$500
Arthroscopic	$250
Ruptured disc	$500
Tendon, ligament or rotator cuff	
Open	$500
Arthroscopic	$250
Thoracic	$750

Follow-up care

Appliances	$100
Follow-up physician's office visit	$75
Prosthetics	
One	$500
Two or more	$500
Transportation	$300 per visit
Rehabilitative therapy	$300 lump sum

Support care

Adult companion lodging	$100 per day

*Age reductions begin at age 65 for employee and spouse. At age 65 to 75%; at age 70 to 50%.

DEFERRED COMPENSATION

WHAT IS A DEFERRED COMPENSATION PLAN?

A Deferred Compensation Plan is a retirement savings option in which an employee elects to defer a portion of their income to be received at a later date, usually upon retirement. This deferral allows employees to postpone paying taxes on the income until it is distributed. Deferred compensation plans are common in both the private and public sectors and serve as a tool to help employees save for retirement while managing their tax liabilities.

PUBLIC SECTOR DEFERRED COMPENSATION PLANS VS. 401(K) PLANS

In the public sector, a common type of deferred compensation plan is the 457(b) plan. This plan is very similar to the private sector's 401(k) plan in terms of structure and benefits, with a few key differences.

SIMILARITIES TO 401(K) PLANS:

- Tax Deferral: Just like a 401(k) plan, contributions to a 457(b) plan are made on a pre-tax basis, reducing the employee's taxable income in the year the contributions are made. The funds in the plan grow tax-deferred, meaning that taxes are only paid when the money is withdrawn, usually at retirement.
- Contribution Limits: Both 457(b) and 401(k) plans have annual contribution limits set by the IRS. For example, in 2026, the limit is $24,500, with an additional catch-up contribution of $8,000 for those aged 50 and older.
- Investment Options: Employees in both plans typically have a variety of investment options, such as mutual funds, target-date funds, and other investment vehicles, allowing them to tailor their retirement savings strategy based on their risk tolerance and retirement goals.
- Portability: Both 457(b) and 401(k) plans offer portability, meaning employees can roll over their funds into another qualified retirement plan or an IRA if they change jobs.

EXAMPLE: PUBLIC SECTOR 457(B) PLAN

- Jane, a city employee, participates in her employer's 457(b) deferred compensation plan. She decides to contribute $10,000 per year to her 457(b) plan. This contribution reduces her taxable income by $10,000 for the year, lowering her overall tax bill.
- Deferred Amount: $10,000 per year
- Tax Impact: Jane does not pay taxes on the $10,000 contribution or any investment gains until she begins to withdraw the money in retirement.
- Growth: The money in her 457(b) plan grows tax-deferred, just like it would in a 401(k) plan.
- Payout: When Jane retires, she can choose to withdraw the funds. Each withdrawal will be taxed as ordinary income.

KEY DIFFERENCES BETWEEN 457(B) AND 401(K) PLANS:

- Withdrawal Penalties: One significant difference is that 457(b) plans do not impose a 10% early withdrawal penalty for distributions taken before age 59½, unlike 401(k) plans. This makes 457(b) plans more flexible for those who may need to access their funds before retirement age.
- Catch-Up Contributions: 457(b) plans have unique catch-up contribution provisions that allow employees nearing retirement to contribute more than the standard limit during the three years leading up to retirement.

WISCONSIN RETIREMENT SYSTEM

The Wisconsin Retirement System was created to protect public employees and their beneficiaries against the financial hardships of old age and disability, to attract and retain a qualified public workforce, establish modest benefits and achieve administrative savings.

Employees who work more than 1,200 hours per year who are expected to be employed for at least one year from the date of hire, are automatically enrolled in the Wisconsin Retirement Fund (WRS). Employee pays amount mandated by law (2025– 6.95%). NOTE: Exception if employee was previously employed at WRS participating employer.

For more information on WRS go to website: http://etf.wi.gov.

ACCESS YOUR WRS STATEMENTS ONLINE

You can now view past Wisconsin Retirement System (WRS) Statements of Benefits online. First-time users will need to create an account with the State of Wisconsin.
Visit: https://etf.wi.gov/my-benefits
Once logged in, you'll have access to your annual WRS statements anytime.

HEALTH SAVINGS ACCOUNT (HSA)

When you are enrolled in a Qualified High Deductible Health Plan (QHDHP) and meet the eligibility requirements, the IRS allows you to open and contribute to an HSA Account.

WHAT IS A HEALTH SAVINGS ACCOUNT (HSA)?

An HSA is a tax-advantaged bank account to pay for eligible health care expenses for you and/or your eligible dependents. The HSA is yours to keep, even if you change jobs or medical plans. There is no "use it or lose it" rule; your balance carries over year to year. You also get extra tax advantages with an HSA.

HSA ELIGIBILITY

In order to open and contribute to an HSA, you must meet these requirements:

- You must be enrolled in a Qualified High Deductible Health Plan (QHDHP)
- You cannot be covered by other non-QHDHP health plan coverage, such as a spouse's PPO plan
- You and/or your spouse cannot be enrolled in a medical Flexible Spending Account (FSA). Enrollment in a Limited Purpose Healthcare FSA is allowed)
- You cannot be enrolled in Medicare, Medicaid or TRICARE,
- You are not eligible to be claimed as a dependent on another person's tax return

FEDERAL TAX ADVANTAGES*

- Reduce income taxes with pre-tax contributions via payroll deductions
- Grow your account – long term savings: interest and investment earnings are tax-free
- Withdraw funds tax-free for qualified healthcare expenses

*States may have different tax treatments

2026 HSA CONTRIBUTIONS

You can contribute to your Health Savings Account on a pre-tax basis through payroll deductions up to the IRS statutory maximums listed below.

- $4,400 Individual
- $8,750 Family
- Age 55 and over may contribute an extra $1,000 catch-up contribution

Village of Germantown will contribute the following to your HSA

- $1,250 Individual
- $2,500 Family

A GUIDE FOR INDIVIDUALS

PNC BeneFit Plus Health Savings Account Overview

Your PNC BeneFit Plus Health Savings Account (HSA) is a great way to pay for healthcare expenses now and in the future. An HSA allows you to take control of your healthcare spending and to save for qualified medical expenses on a tax-advantaged basis. It's easy — you can gain tax savings on contributions to your account, invest your funds and let them grow tax-free. Withdrawals from your account are tax-free when you use the funds for qualified medical expenses.

Health Savings Account Benefits

Tax-advantaged

You may benefit from tax-advantaged contributions, investment earnings and withdrawals for qualified medical expenses.[1,2]

Ownership

You own your account and the money in the account, even if your employer contributes to it.

Long-term savings

Unused funds roll over from year-to-year. The funds invested can help you to build financial security for retirement savings or to pay for unexpected medical expenses. You may be able to access unused balances to supplement retirement income after age 65, subject to applicable income taxes.[2]

Portability

Your money stays with you even if you switch jobs, change medical coverage, become unemployed or retire.

Managing Your HSA is Easy

PNC BeneFit Plus can make all aspects of managing your account easy with the following features:

Easy to open

You will receive a welcome email notification and/or letter with instructions on a few simple steps to activate your account.

Easy to contribute

You can contribute via payroll deduction and make scheduled or one-time contributions from your personal bank account, or make check contributions through the U.S. mail. Contributions made outside of your payroll deductions are eligible for tax deductions on your tax return.[2]

Here are some other things you need to know about contributing to your HSA

- There are annual limits set by the IRS for how much you can contribute.[4]
- Those over age 55 may also be eligible to make a catch-up contribution.[4]
- You have until April 15 to make your full contribution for the prior tax year.[2]
- You can check the Consumer Portal to see your total contributions for the current tax year.

Easy to grow

Your HSA includes an FDIC-insured deposit account (covered to the extent permitted by law) with tiered interest rates. Plus, you can choose to invest in a variety of mutual funds upon meeting certain minimum balance requirements and watch your money grow tax-free.[2,3]

Easy to access

PNC offers several ways to help you manage your account(s):

- Access your account online — View your account balance and transaction history for your HSA via the PNC BeneFit Plus Consumer Portal and enjoy a robust set of notifications, including several text messaging options.
- Manage your account while on the go with the PNC BeneFit Plus Mobile App.[5]
- Call Customer Service — Toll-free account owner customer service is available with PNC BeneFit Plust Consumer Services at 1-844-356-9993 from 8 a.m. – 10 p.m. ET Monday – Friday, excluding holidays, or via email at **pncbenefitplus@healthaccountservices.com**
- View statements — Monthly statements reflect both your Current Period and Year-to-Date balance and transaction information.

What you need to know about Qualified Medical Expenses

- You are responsible for making sure that distributions are for qualified medical expenses.[1]
- You are responsible for keeping receipts in the event of a personal audit.
- HSA funds used for non-qualified medical expenses are subject to taxes and a penalty. At age 65, employees can use HSA funds for non-qualified expenses without a penalty but will still incur income taxes.[2]

Easy to make payments

Pay for qualified medical expenses in the way that's easiest for you:

- Present your PNC BeneFit Plus debit card at the point of sale.
- Use the PNC BeneFit Plus Consumer Portal to make an online transfer from your HSA to a personal bank account to reimburse yourself electronically.
- Online BillPay — Pay a healthcare provider directly online.

Download the **PNC BeneFit Plus Mobile App** today

Download on the App Store

GET IT ON Google Play

Download the PNC BeneFit Plus Mobile App today

1. Go to the App Store® or Google Play™
2. Search for "PNC BeneFit Plus"
3. Download the PNC BeneFit Plus Mobile App

Mobile Capabilities

The PNC BeneFit Plus Mobile App[5] allows you to:

- Check balance information and view transaction details.
- Request HSA distributions and make HSA contributions
- Utilize the "Expense Tracker" tool to upload receipts for record keeping
- Email customer service directly with questions

Ready to Help

For more information on your Health Savings Account options, visit **pnc.com/pncbenefitplus**, call PNC BeneFit Plus Consumer Services at **844-356-9993** and/or contact your employer.

A Part of **PNC Organizational Financial Wellness**

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Account (FSA) plan with Diversified Benefit Services, Inc. allows you to set aside tax-free dollars each year to cover eligible out-of-pocket health care, dental, vision, or dependent care expenses.

FSA BASICS

- Elected FSA contributions are deducted from your pay on a pre-tax basis
- You cannot change your contribution during the plan year unless you experience a qualifying life event (QLE)
- Expenses must be incurred during the specified plan year
- You may submit claims for expenses incurred within the enrollment period
- Up to $660 of unused Health Care FSA monies from 2025 will automatically roll over and will be available in 2026.
- **Use it or lose it!** It is important to plan your contribution amounts carefully. The Internal Revenue Service requires that you forfeit any money for which you have not incurred eligible expenses by the end of the plan year.

HEALTH CARE FSA

Funds that you set aside in a Health Care FSA can be used to reimburse eligible health care expenses for you and your eligible family members (spouse, children, tax dependents) not covered under the medical, prescription drug, dental or vision plans. Reimbursements can be made for most expenses that would qualify for a health care deduction on your income tax return.
Eligible expenses include out-of-pocket Medical, Pharmacy, Dental, and Vision expenses, such as copays, deductibles, and coinsurance. A complete list of eligible Health Care FSA expenses can be accessed at www.dbsbenefits.com.

DEPENDENT CARE SPENDING ACCOUNT

A Dependent Care Spending Account allows you to set aside tax-free dollars each year to cover eligible dependent care expenses to help you (and your spouse) work, look for work or attend school full-time. Eligible expenses include: childcare for children or who are under age 13 years old (e.g., day care or day camp) or care for an adult dependent who is unable to care for themselves. A complete list of eligible Dependent Care expenses can be accessed at www.website.com.
Dependent Care claims will be reimbursed only up to your account's current balance. If a dependent care expense exceeds the dependent care balance, you'll be reimbursed the additional amount as contributions are made to your account through your payroll deductions.

2026 Maximum Contribution Amounts	
Health Care FSA	$3,400
Dependent Care FSA	$7,500

FLEXIBLE BENEFIT PLAN ONLINE ENROLLMENT INSTRUCTIONS

HOW TO CREATE AN A.S.A.P.® ACCOUNT:

DIVERSIFIED
BENEFIT SERVICES

1. Use one of the following options:
    a. Option 1: Using the link below
    - https://asap-online-login.dbsbenefits.com/Account/RegisterPin?Pin=VillageofGermantown
    b. Option 2: Go to the DBS website at DBSbenefits.com or Download the Diversified Benefit Services App
    - Enter your employer PIN: **VillageofGermantown**
2. Complete demographic information and click '**Register'**. A message will indicate your account has been successfully created.
3. Check your email and click the link within the registration confirmation email to create your password.
4. Enter a password and select '**Set Password'**. Your online account will be created, and you may now complete the online enrollment.

HOW TO ENROLL:

1. Log into your online A.S.A.P.® account.
2. Select the **01/01/2026** plan year on the top of the screen and then select **'Enrollment'** from the menu bar.
3. Complete the enrollment information as asked for on the online enrollment form.
4. Direct Deposit of claim reimbursements is a requirement of your plan. You will need to complete the bank account information section of the online enrollment form in order to submit your enrollment. If you are a current FSA participant, your current bank information will auto-fill on the screen. You can update banking information or proceed with the current information.
5. Review the '**Legal Terms'** and check the box if you agree to the stated terms (required in order to enroll).
6. Next click on the red **'Click Here to Submit Enrollment'** button. A window will pop up confirming you have successfully enrolled and providing the details of your enrollment.
7. You will have an option to print the enrollment form by clicking on the **'Print Your Enrollment'** box.
8. When finished click on the **'Logout'** link at the top of the page.

EMPLOYEE ASSISTANCE PLAN (EAP)

Aurora Health Care Employee Assistance Program is a free, confidential counseling assessment and referral service for employees and their household family members. The EAP provides access to trained professionals in individual, marriage and family counseling, as well as employee assistance.

You can call or chat with an EAP counselor 24/7/365. You also have access to 3 face-to-face sessions with a specialist per incident. Counselors will be able to assess your situation, recommend an action plan, and/or refer you to other resources if necessary.

All calls into the EAP program are 100% confidential. Participation is not documented and will not be reported to your Employer.

- Need to talk to someone?
- Need a lawyer?
- Challenging children?
- Communication problems?
- Need help budgeting?
- Concerned about drinking too much?
- Looking for information on schools?
- Can't sleep because of worry?
- Have a legal question?
- Problems at school?
- Struggling with a challenging relationship?
- Planning for retirement?
- Feeling down?
- Elder care concerns?
- Feeling stressed?
- Marriage in trouble?
- Interested in adoption?
- Planning for college?
- Have a mediation question?
- Struggling with depression?
- Feeling anxious?
- Substance abuse concerns?

The Advocate Aurora EAP is a free benefit for all employees and their immediate household members. Sessions with EAP counselors are confidential as specified by state and federal law.

Access EAP services by calling **1-800-236-3231**
Call 24/7 to speak with an EAP counselor
Visit our website at www.aah.org/eap

HELPFUL RESOURCES

USI MOBILE APP – MYBENEFITS2GO

The Village of Germantown is pleased to offer on-the-go access to key benefit information through the USI EB Mobile App. Download in the App Store or Google Play Store and enter code K30770 in the app to access your benefit highlights.

Highlights of the MyBenefits2GO App

- Access benefits information on the go
- Convenient contact information for Carriers and HR
- Organized plan information in one place
- View the most updated plan information
- Store your ID cards in the app

USI BENEFIT RESOURCE CENTER

Have Questions? Need Help?

Village of Germantown is excited to offer access to the USI Benefit Resource Center (BRC), which is designed to provide you with a responsive, consistent, hands-on approach to benefit inquiries. Benefit Specialists are available to research and solve elevated claims, unresolved eligibility problems, and any other benefit issues with which you might need assistance. The Benefit Specialists are experienced professionals, and their primary responsibility is to assist you.

The BRC is open Monday through Friday 8:00am to 5:00pm Eastern & Central Standard Time

CONTACT THE BRC

- EMAIL BRCMidwest@usi.com
- CALL 855-874-0829
- Click here to learn more about the BRC

IMPORTANT CONTACTS

Additional information regarding benefit plans can be found at www.germantownwi.gov/678/information-for-employees. Please contact Human Resources to complete any changes to your benefits that are not related to your initial or annual enrollment.

	Carrier	Phone Number	Website
Medical	UnitedHealthcare Insurance Company	1-800-826-9781	www.umr.com
Dental	Delta Dental Insurance Company	1-800-236-3712	www.deltadentalwi.com
Vision	MetLife	1-800-638-5433	www.metlife.com
Health Savings Account (HSA)	PNC Bank	844-356-9993	pnc.com/pncbenefitplus
Flexible Spending Account (FSA)	Diversified Benefit Services	262-367-3300	www.dbsbenefits.com
Accident	Securian	1-866-295-8690	https://etf.wi.gov/
Income Continuation	The Hartford	1-800-960-0052	https://etf.wi.gov/
Life Insurance	Securian	1-866-295-8690	https://etf.wi.gov/
Wellness	Vitality	877-224-7117	www.powerofvitality.com
Wisconsin Retirement System	WRS	1-877-533-5020	https://etf.wi.gov/
Employee Assistance Program (EAP)	Aurora	800-236-3231	https://employersolutions.aah.org/eap/employee/

This brochure summarizes the benefit plans that are available to the Village of Germantown eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. The information provided in this brochure is not a guarantee of benefits.

IMPORTANT LEGAL NOTICES AFFECTING YOUR HEALTH PLAN COVERAGE

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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

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

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

NOTICE OF SPECIAL ENROLLMENT RIGHTS

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

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.

- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.
No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan reviewed and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Gosia Wormsnacher
Germantown, WI 53022
262-250-4750
gwormsbacher@germantownwi.gov

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***Please review it carefully****.*
Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.

- We may say “no” to your request, but we’ll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/hipaa/filing-a-complaint/index.html**.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share**.**

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases, we never share your information unless you give us written permission:
  Marketing purposes
  Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims

- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice

- 10.1.2026
- Gosia Wormsnacher, 262-250-4750, gwormsbacher@germantownwi.gov

MODEL INDIVIDUAL **CREDITABLE COVERAGE** DISCLOSURE NOTICE LANGUAGE FOR USE ON OR AFTER APRIL 1, 2011

If you are receiving a copy of this notice electronically, you are responsible for providing a copy of it to any Part-D eligible dependents covered under the group health plan.

Important Notice from Village of Germantown 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 Village of Germantown 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. Village of Germantown has determined that the prescription drug coverage offered by the Village of Germantown's Medical Plans for the plan year 2026 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, the following options may apply:

- You may stay in the Village of Germantown's Medical Plans and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date without penalty either:
    - During the Medicare prescription drug annual enrollment period, or
    - If you lose Village of Germantown's Medical Plans creditable coverage.
- You may stay in the Village of Germantown's Medical Plans and also enroll in a Medicare prescription drug plan. The Village of Germantown's Medical Plans will be the primary payer for prescription drugs and Medicare Part D will become the secondary payer.
- You may decline coverage in the Village of Germantown's Medical Plans and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do not enroll in the Village of Germantown's Medical Plans, you are not able to receive coverage through the plan unless and until you are eligible to reenroll in the plan at the next open enrollment period or due to a status change under the cafeteria plan or special enrollment event.

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 Village of Germantown 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 Village of Germantown 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).

Name/Entity of Sender:	Village of Germantown
Contact Position/Office:	Gosia Wormsbacher
Address:	N112W17001 Mequon Road Germantown WI 53022
Phone Number:	(262)-250-4750

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, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**

Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
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	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – 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://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**

Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	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)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

U.S. Department of Health and Human Services

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

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, and displays 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 person shall 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 1/31/2026)

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] 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.[2]

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 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.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023, and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

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

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact:

Name of Entity/Sender:	Village of Germantown
Contact--Position/Office:	Gosia Wormsbacher
Address:	N112W17001 Mequon Road Germantown WI 53022
Phone Number:	(262)-250-4750

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.

PART B: Information About Health Coverage Offered by Your Employer

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

• Employer Name Village of Germantown		4. Employer Identification Number (EIN)
• Employer address N112W17001 Mequon Road		• Employer phone number (262) 250-4750
• City Germantown	• State WI	• City Germantown
• Who can we contact about employee health coverage at this job? Gosia Wormsbacher		
11. Phone number (if different from above)	12. Email address gwormsbacher@germantownwi.gov	

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

- As your employer, we offer a health plan to:
  - [X] All employees. Eligible employees are:
    1. Employees working 30 or more hours per week
  - [ ] Some employees. Eligible employees are:

- With respect to dependents:
  - [ ] We do offer coverage. Eligible dependents are:
    - Your legally married spouse;
    - Your children up to age 26;
    - An unmarried disabled child over the age of 26 who meets certain conditions

    Consult the SPD for the relevant plan for the details on who qualifies as a dependent under that plan.
  - [ ] We do not offer coverage.

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

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

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