Village of Germantown

2025 BENEFITS GUIDE

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Inside the Guide

Welcome

At the 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 benefits package that is easy to understand, easy to access and affordable for all our employees. This brochure will help you choose the type of plan and level of coverage that is right for you.

The Village understands that insurance is complicated, so that we are adding a new mobile app to keep all of your insurance information at your fingertips. Here, you can find all plan information, store ID cards, and access our benefits resource center through the USI mobile app.

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

Sincerely,
Erin Hirn

Access your benefits insurance policy details and contact information on the go!

FIND IT IN THE APP STORE

Search for 'MyBenefits2GO' and download our free app. After scrolling through the intro pages

Enter this code when prompted: K30770 to access

Village of Germantown benefit details.

HIGHLIGHTS OF THE MyBenefits2GO APP

- Stay Organized – Access all your plan information and cards in one place
- Stay Up To Date – Receive the most updated plan information automatically
- Lighten Up Your Wallet – Store your cards in the app
- Get In Touch – Convenient contact information

Call the Benefit Resource Center ("BRC"), We're Here To Help!

We speak insurance. Our Benefits Specialists can help you with:

- Deciding which plan is the best for you
- Benefit plan & policy questions
- Eligibility & claim problems with carriers
- Information about claim appeals & process
- Allowable family status election changes
- Transition of care when changing carriers
- Claim escalation, appeal & resolution
- Medicare basics with your employer plan
- Coordination of benefits
- Finding in-network providers
- Access to care issues
- Obtaining case management services
- Group disability claims

USI®

Benefit Resource Center

BRCMidwest@usi.com | Toll Free: 855-874-0829

Monday through Friday 8:00am to 5:00pm Eastern & Central Standard Time

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:

If you are eligible for our benefits, then your dependents are too. In general, eligible dependents include your spouse and 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. Children may include natural, adopted, stepchildren and children obtained through court-appointed legal guardianship.

When Coverage Begins:

Newly hired employees and dependents will be effective in Village of Germantown's benefits programs immediately following the 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.

Medical

	UMR Gold Plan		UMR Silver Plan	
	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits
Annual Deductible				
Individual	$1,000	$1,250	$3,000	$6,000
Family	$2,000	$2,500	$6,000	$12,000
Embedded or Aggregate	Embedded	Embedded	Aggregate	Aggregate
Coinsurance	90%	70%	100%	70%
Maximum Out-of-Pocket				
Individual	$5,000	$10,000	$3,000	$12,000
Family	$10,000	$20,000	$6,000	$24,000
Physician Office Visit				
Teladoc	$0 copay		$50 copay	
Primary Care	$30 copay per visit; dedutible / coinsurance for other services	70% after deductible	100% after deductible	70% after deductible
Specialty Care	$45 copay per visit; dedutible / coinsurance for other services	70% after deductible	100% after deductible	70% after deductible
Preventive Care				
Adult Periodic Exams	100%	70% after deductible	100%	70% after deductible
Well-Child Care	100%	70% after deductible	100%	70% after deductible
Diagnostic Services				
Urgent Care Visit	$75 copay	70% after deductible	100% after deductible	70% after deductible
Emergency Room Facility Charges*	$300 copay	$300 copay	100% after deductible	70% after deductible
Inpatient & Outpatient Facility Charges**	Deductible then 90% after deductible	70% after deductible	100% after deductible	70% after deductible
Other Services				
Chiropractic	90% after deductible	70% after deductible	100% after deductible	70% after deductible
Retail Pharmacy (30 Day Supply)				
Generic (Tier 1)	$15 copay	$30 (90 day) mail order	100% after deductible	70% after deductible
Preferred (Tier 2)	$45 copay	$90 (90 day) mail order	100% after deductible	70% after deductible
Non-Preferred (Tier 3)	$90 copay	$180 (90 day) mail order	100% after deductible	70% after deductible
Preferred Specialty (Tier 4)	20% cost up to $150 maximum	20% cost up to $150 maximum (90 day)	100% after deductible	70% after deductible

*Copay may be waived if admitted
**Pre-authorization is required for hospital, surgical and maternity services

Employee Contributions (Per Pay Cycle)				
Single Coverage	**Silver Plan**		**Gold Plan**	
2025 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	$900.22	$900.22	$1,052.66	$1,052.66
Village Monthly Share	$792.19	$675.17	$926.34	$789.50
Employee Monthly Share	$108.03	$225.06	$126.32	$263.17
Pay Period Deduction Amount	**$54.01**	**$112.53**	**$63.16**	**$131.58**
Family Coverage	**Silver Plan**		**Gold Plan**	
2025 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	$2,160.94	$2,160.94	$2,525.56	$2,525.56
Village Monthly Share	$1,901.63	$1,620.71	$2,222.49	$1,894.17
Employee Monthly Share	$259.31	$540.23	$303.07	$631.39
Pay Period Deduction Amount	**$129.66**	**$270.12**	**$151.53**	**$315.70**

Coverage Examples	Gold Plan		Silver Plan	
	High Claims	**Low Claims**	**High Claims**	**Low Claims**
Deductible	$1,000	$300	$6,000	$600
Copays	$725	$30	$0	$0
Coinsurance	$2,000	$0	$0	$0
HSA Seeding	$0	$0	$2,500	$2,500
Total Cost	**$3,725**	**$330**	**$3,500**	**$1,900 extra paid to employee**

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

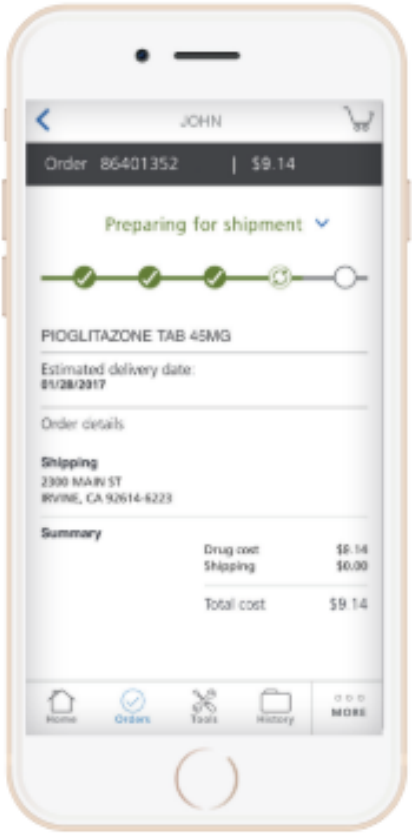
The OptumRx app gives you quick access to your plan's most current drug coverage information.

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

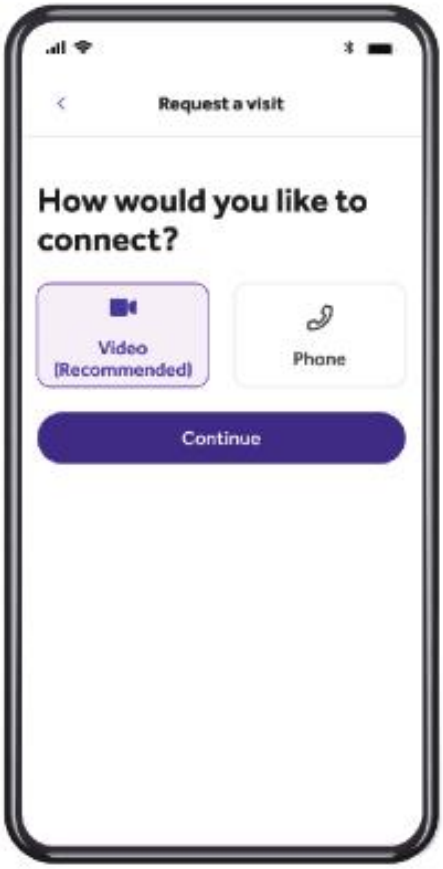
Compare prescription drug options and identify potential cost savings.



Teladoc HEALTH | Village of Germantown

The right care when you need it most

Here for you anytime, anywhere, by phone or video.



Your Teladoc Health service(s):

General Medical (24/7 Care) | $54 or less/visit
Get same-day virtual visits for non-urgent and common conditions.

Mental Health
$95 or less/therapy visit
$235 or less/psychiatry first visit
$105 or less/psychiatry ongoing visit
Talk to a therapist of your choice 7 days a week.

Dermatology | $85 or less/online review
Upload images of a skin issue for a treatment plan from a dermatologist in 24 hours or less.

Get started

Visit Teladoc.com
Call 1-800-TELADOC (800-835-2362) | Download the app

Refer to your employee booklet at umr.com for Teladoc benefits

Vitality®
Let's Get Started!

Be a Goal-Getter!

Get Started with the Power of Vitality®

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

Need Assistance?

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

Scan to download or open the Power of Vitality mobile app

Dental

The Village of Germantown will continue to offer a dental program at no cost to you!

Please refer to the summary plan description for complete plan details

	Delta Dental Insurance Company	
	In-Network Benefits	Out-of-Network Benefits
Annual Deductible		
Individual	$25	$25
Family	$75	$75
Waived for Preventive Care?	Yes	Yes
Annual Maximum		
Per Person / Family	$1,300	$1,300
Preventive	100%	100%
Basic	80% after deductible	80% after deductible
Major	50% after deductible	50% after deductible
Orthodontia		
Benefit Percentage	50%	50%
Adults (and Covered Full-Time Students, if Eligible)	Not Covered	Not Covered
Dependent Child(ren)	Covered (up to age 19)	Covered (up to age 19)
Lifetime Maximum	$1,000	$1,000

Vision

	Delta 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	Not covered
Frames / Lenses Copay	$0 copay; $150 allowance, 20% off balance over $150	$70
Lenses benefit frequencey – 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	$30
Bifocal	$25 copay	$50
Trifocal	$25 copay	$65
Lenticular	$25 copay	$100
Lens Upgrades		
Polycarbonate lenses	$35 copay (adult) $0 (child)	Not covered
Tinting of plastic lenses	$15 copay	Not covered
Progressive lenses	Standard: $0 copay Premium: $95 - $200 copay	$50
Contact Lenses – covered only in lieu of eyeglasses lenses		
Convential contacts	$0 copay; $150 allowance; 15% off a balance over $150	$105
Disposable contacts	$0 copay; $150 allowance	$105
Medically necessary contacts	$0 copay; paid in full	$210
Contact lens fit and follow-up	Standard: Up to $40 copay Premium: 10% off retail price	Not covered

Vision Monthly Premiums		
	Active Employee	**Retiree**
Employee	$5.72	$5.72
Employee + Spouse	$11.42	$11.42
Employee + Child(ren)	$12.88	$11.42
Family	$20.58	$13.41

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.

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

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

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 concssions, fractures, dislocations, lacerations, emergency room treatmetn, x-rays, hospitilzation, surgeries, follow-up care, support care, accident death & dismemberment (up to $100,000), identity theft, and trael 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 2025, the limit is $22,500, with an additional catch-up contribution of $7,500 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.

Flexible Spending Accounts

The Flexible Spending Account (FSA) plan with Diversified Benefit Services, Inc. allows you to set aside pre-tax dollars to cover qualified expenses you would normally pay out of your pocket with post-tax dollars. The plan is comprised of a health care spending account and a dependent care account. You pay no federal or state income taxes on the money you place in an FSA.

How an FSA works:

- Choose a specific amount of money to contribute each pay period, pre-tax, to one or both accounts during the year.
- The amount is automatically deducted from your pay at the same level each pay period.
- As you incur eligible expenses, you may use your flexible spending debit card to pay at the point of service OR submit the appropriate paperwork to be reimbursed by the plan.

Maximum Annual Election	
Health Care FSA	$3,200
Limited Purpose FSA	$3,200
Dependent Care FSA	$5,000

Important rules to keep in mind:

- The IRS has a strict "use it or lose it" rule. If you do not use the full amount in your FSA, you will lose any remaining funds.
- Once you enroll in the FSA, you cannot change your contribution amount during the year unless you experience a qualifying life event.
- You cannot transfer funds from one FSA to another.

Please plan your FSA contributions carefully, as any funds not used by the end of the year will be forfeited. Re-enrollment is required each year.

Account Options:

- Health Care Spending Account
- Limited Purpose Health Care Spending Account
  - Note: if you have an HSA, the FSA can only be used for dental and vision expenses
- Dependent Spending Account

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-sheltered bank account that you own to pay for eligible health care expenses for you and/or your eligible dependents for current or future healthcare expenses. The Health Savings Account (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.

Plus, you get extra tax advantages with an HSA because:

- Money you deposit into an HSA is exempt from federal income taxes
- Interest in your account grows tax free; and
- You don't pay income taxes on withdrawals used to pay for eligible health expenses. (If you withdraw funds for non-eligible expenses, taxes and penalties apply).
- You also have a choice of investment options which earn competitive interest rates, so your unused funds grow over time.

Are you eligible to open a Health Savings Account (HSA)?

Although everyone can enroll in the Qualified High Deductible Health Plan, not everyone is eligible to open and contribute to an HSA. If you do not meet these requirements, you cannot open an HSA.

- You must be enrolled in a Qualified High Deductible Health Plan (QHDHP)
- You must not be covered by another non-QHDHP health plan, such as a spouse's PPO plan.
- You are not enrolled in Medicare.
- You are not in the TRICARE or TRICARE for Life military benefits program.
- You have not received Veterans Administration (VA) benefits within the past three months.
- You are not claimed as a dependent on another person's tax return.
- You are not covered by a traditional health care flexible spending account (FSA). This includes your spouse's FSA. (Enrollment in a limited purpose health care FSA is allowed).

2025 HSA Contributions

You can contribute to your Health Savings Account on a pre-tax basis through payroll deductions up to the IRS statutory maximums. The IRS has established the following maximum HSA contributions:

Maximum Annual Election	
Individual	$4,300
Family	$8,550
Village of Germantown's Contributions	
Individual	$1,250
Family	$2,500

- If you are age 55 and over, you may contribute an extra $1,000 catch up contribution.

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

App Store | 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**

Employee Assistance Plan (EAP)

Life does not always go smoothly. All of us experience times when a personal problem or crisis affects the way we function at work or home. Your Employee Assistance Program (EAP) is a problem-solving resource available to you and your household members. A professional counselor will assist you in assessing your situation, finding options, making choices or locating further help.

It's free... Your employer covers the cost of initial assessment, additional problem-solving sessions and referral services. If there is a need for further counseling or treatment, your counselor will help you explore various options.

It's confidential... Your EAP has been set up with Aurora, an outside counseling resource to assure confidentiality. No one at work will know you have chosen to seek help unless you choose to tell them. Nothing concerning your use of EAP will appear in your personnel file.

Aurora is only a phone call away at 800-236-3231.

Changes in Benefit Elections

Open Enrollment:

With a 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.

Important Contacts

USI Mobile App

Village of Germantown is pleased to offer on-the-go access to key benefit information through the USI Mobile App, MyBenefits2GO. Download it in the App Store or Google Play Store and enter code K30770 in the app to access your benefit highlights.

Benefit Resource Center ("BRC")

Contact the BRC for insurance-related questions. Email us at BRCMidwest@usi.com or call 855-874-0829 Monday through Friday 8am to 5pm.

Carrier Customer Service

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	Delta Vision Insurance Company	1-800-236-3712	www.deltadentalwi.com
Health Savings Account (HSA)	PNC Bank	844-356-9993	pnc.com/pncbenefitplus
Flexilbe Spending Account (FSA)	Diversified Benefit Services	262-367-3300	www.dbsbenefits.com
Accident	Securian	1-866-295-8690	https://etf.wi.gov/
Income Continutation	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
Health Savings Account	PNC	262-250-6303	www.pnc.com
Employee Assistance Program (EAP)	Aurora	800-236-3231	https://employersolutions.aah.org/eap/employee/

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.

Required Notifications

Important Legal Notices Affecting Your Health Plan Coverage

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 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.

CONTACT INFORMATION

Questions regarding any of this information can be directed to:
Erin Hirn
Germantown United States
262-250-4750
ehirn@germantownwi.gov
«Notice of Privacy Practices»

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Your Information. Your Rights. Our Responsibilities.

Recipients of the notice are encouraged to read the entire notice. 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

- 01.01.2025 effective date of this notice
- Erin Hirn, Support Services Manager, (262) 250-4750, ehirn@germantownwi.gov

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

If you are receiving this electronically, you are responsible for providing a copy of this notice to any Medicare Part D-eligible dependents who are 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 Medical PP Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

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

If you decide to join a Medicare drug plan, your current Village of Germantown coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current Village of Germantown coverage, be aware that you and your dependents will be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with 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 Erin Hirn at 262-250-4750. **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.

CMS Form 10182-CC **Updated April 1, 2011**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

OMB 0938-0990

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

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).

CMS Form 10182-CC **Updated April 1, 2011**

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Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawk)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.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: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.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

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 January 31, 2024. 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

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. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: 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.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	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	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
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 January 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displa ys 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.[1,2]

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 of these factors in determining whether to purchase a health plan through the Marketplace.

[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.

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.

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

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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.

3. Employer Name Village of Germantown		4. Employer Identification Number (EIN)
4. Employer address N112W17001 Mequon Road		5. Employer phone number (262) 250-4750
6. City Germantown	7. State WI	8. ZIP code 53022
9. Who can we contact about employee health coverage at this job? Erin Hirn		
11. Phone number (if different from above)	12. Email address ehirn@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:
  - [ ] Some employees. Eligible employees are:
- With respect to dependents:
  - [x] 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.

[x] 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.

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

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

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

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

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

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

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