EMPLOYEE BENEFITS GUIDE

bellinhealth

01/01/2024-
12/31/2024
Plan Year

11.27.23

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Welcome To Bellin!

At Bellin Health 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 booklet will help you choose the type of plan and level of coverage that is right for you.

You can also view more details about our benefit plans by accessing our benefit website, BellinBenefits.org.

In addition, questions may be emailed to employeebenefits@bellin.org.

Sincerely,

Bellin Benefits Team, Human Resource Management

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Official Healthcare Partner of the Green Bay Packers

Contact Information

Please contact Human Resources if you need to complete any changes to your benefits that are not related to your initial or annual enrollment (life event changes). You can also view Life Event information on BellinBenefits.org.

Benefit Carrier Customer Service

	CARRIER	PHONE NUMBER	WEBSITE
Medical Health Plans PPO and HDHP	HealthPartners, Inc.	(866) 443-9352	www.healthpartners.com/bellin
Dental PPO	HealthPartners, Inc.	(866) 443-9352	www.healthpartners.com/bellin
Vision	MetLife	(833) 393-5433	www.metife.com/mybenefits
Life and AD&D	Unum Life Insurance Company of America	(800) 421-0344	www.unum.com
Voluntary Life and AD&D	Unum Life Insurance Company of America	(800) 421-0344	www.unum.com
Short Term Disability (STD)	Unum Life Insurance Company of America	(800) 421-0344	www.unum.com
Long Term Disability (LTD)	Unum Life Insurance Company of America	(800) 421-0344	www.unum.com
Voluntary Long Term Disability (VLTD)	Unum Life Insurance Company of America	(800) 421-0344	www.unum.com
Employee Supportive Services (LifeMatters)	Empathia, Inc.	(800) 634-6433	www.mylifematters.com (Password = Bellin1)
Flex Spend Account (FSA)	WEX Inc.	(866) 451-3399	www.wexinc.com
Health Savings Account (HSA)	Empower	(800) 331-5455	https://mybhsretirement.com
Retirement Plan (401k)	Empower	(877) 825-5594	https://mybhsretirement.com

Human Resources

Email: employeebenefits@bellin.org
Phone: (920) 445-7240, Option 3

Si habla español, puede obtener asistencia para ayudarlo a revisar la información de beneficios y completar la inscripción de beneficios llamando al 920-445-7240.

Es su responsabilidad solicitar asistencia para completar la inscripción y cualquier elemento de beneficio requerido antes de las fechas límite comunicadas.

Additional information, summary plan descriptions (SPD), Summary of Benefits Coverage (SBC) and web links to benefit vendors for benefit plans can be found on BellinBenefits.org.

Eligibility

Who is Eligible:

You may enroll in the Bellin Health Employee Benefits Program if you are a full-time (.8 - 1.0 FTE) or part-time (.5 - .7 FTE) employee working at least 20 hours per week.

When Coverage Begins:

New Hires/Newly Eligible

Coverage for newly hired/newly eligible employees and dependents will be effective in Bellin Health's benefits programs the 1st of the month following date of hire/date of moving to benefit eligible status. All elections are in effect for the entire plan year and can only be changed during Annual Open Enrollment, unless you experience a qualifying life event (marriage, divorce, birth/adoption of a child, loss or gain of other coverage). Enrollment changes due to life events must be completed within 30 days of the event.

Annual Open Enrollment

Benefits elected during Annual Open Enrollment are effective January 1 of the next plan year.

Eligible Dependents:

Your dependents are also eligible for our benefits. Eligible dependents include your legally married 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, step-children and children obtained through court-appointed legal guardianship. **You will need to submit proof of dependent eligibility for any dependents enrolled on your health, dental, vision or voluntary life benefits.**

When Coverage Ends:

All benefits end on your last day worked, or last day in a benefit eligible position.

Enrollment

Enrolling in benefits is completed online in the Employee Space (Infor) system. Follow the steps below:

1. After reviewing the benefit information and when you are ready to enroll, go to the New Hires & Newly Eligible page and open the Online Enrollment Guide on BellinBenefits.org.

2. Log into your Employee Space (Infor) account using your Bellin email and network password. Click the Enrollment Events icon on the Welcome screen.

3. Select the Life Events tab. Under the My Current Life Events heading, click on the link to Continue the New Hire or Newly Eligible event.

4. First, add your dependents and beneficiaries information, so you can enroll them or designate them in benefits later in the process.

5. Next, advance through each benefit screen to enroll yourself and dependents or waive the benefit. Use the Online Enrollment Guide as needed.

6. Review and Submit – Correct any errors and submit your enrollment to receive your confirmation.

IMPORTANT REMINDER

You will have 30 days from your hire date/newly eligible date to enroll.

TERMS YOU NEED TO KNOW

Deductible:
A fixed dollar amount that you pay before the plan will begin paying benefits.

Co-Insurance:
A percentage of medical plan costs that you pay after your deductible is met.

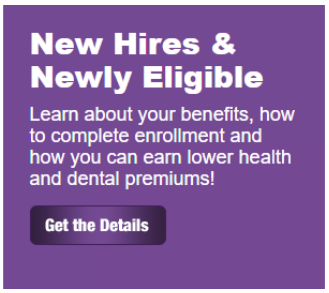
Out-of-Pocket Maximum:
The maximum you will pay for your medical benefits until covered treatment is paid at 100%.

In-Network:
Doctors, hospitals, and other providers with whom the medial plan has an agreement to care for its members. Covered employees and dependents have lower out-of-pocket costs when using in-network providers.

Out-of-Network:
Care received from a doctor, hospital, or provider with whom the plan does not have an agreement. Covered employees and dependents pay more to use out-of- network providers.

Primary Care Provider (PCP):
PCPs are Family Practitioners, Internists, Pediatricians, Nurse Practitioners, or Physician Assistants.

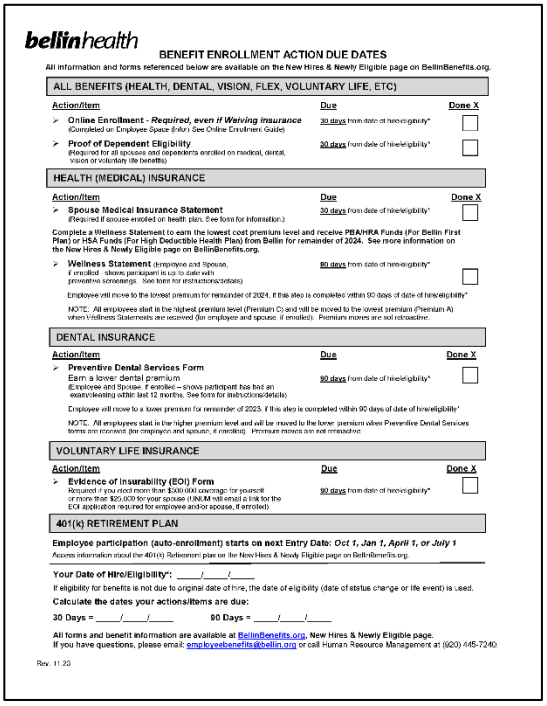
Benefit Plan Materials and Forms



Go to BellinBenefits.org New Hires & Newly Eligible page for

- Online Enrollment Guide
- Links to all benefit pages
- Recorded benefit presentations
- Link to Bellin Wellness Rewards (Wellness Statement)
- Links to Forms and Benefit Action Due Dates Checklist
- Links to benefit vendor accounts

Use the Benefit Action Due Dates Checklist on this page to make sure you don't miss important benefit deadlines.



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BENEFIT ENROLLMENT ACTION DUE DATES

All information and forms referenced below are available on the New Hires & Newly Eligible page on BellinBenefits.org.

ALL BENEFITS (HEALTH, DENTAL, VISION, FLEX, VOLUNTARY LIFE, ETC)

Action/Item	Due	Done X
➢ **Online Enrollment** - ***Required, even if Waiving insurance*** (Completed on Employee Space (Infor) See Online Enrollment Guide)	30 days from date of hire/eligibility*	☐
➢ **Proof of Dependent Eligibility** (Required for all spouses and dependents enrolled on medical, dental, vision or voluntary life benefits)	30 days from date of hire/eligibility*	☐

HEALTH (MEDICAL) INSURANCE

Action/Item	Due	Done X
➢ **Spouse Medical Insurance Statement** (Required if spouse enrolled on health plan. See form for information.)	30 days from date of hire/eligibility*	☐

Complete a Wellness Statement to earn the lowest cost premium level and receive PBA/HRA Funds (For Bellin First Plan) or HSA Funds (For High Deductible Health Plan) from Bellin for remainder of 2024. See more information on the New Hires & Newly Eligible page on BellinBenefits.org.

➢ **Wellness Statement** (Employee and Spouse, if enrolled - shows participant is up to date with preventive screenings. See form for instructions/details)	60 days from date of hire/eligibility*	☐

Employee will move to the lowest premium for remainder of 2024, if this step is completed within 90 days of date of hire/eligibility*

NOTE: All employees start in the highest premium level (Premium C) and will be moved to the lowest premium (Premium A) when Wellness Statements are received (for employee and spouse, if enrolled). Premium moves are not retroactive.

DENTAL INSURANCE

Action/Item	Due	Done X
➢ **Preventive Dental Services Form** Earn a lower dental premium (Employee and Spouse, if enrolled – shows participant has had an exam/cleaning within last 12 months. See form for instructions/details)	90 days from date of hire/eligibility*	☐

Employee will move to a lower premium for remainder of 2023, if this step is completed within 90 days of date of hire/eligibility*

NOTE: All employees start in the higher premium level and will be moved to the lower premium when Preventive Dental Services forms are received (for employee and spouse, if enrolled). Premium moves are not retroactive.

VOLUNTARY LIFE INSURANCE

Action/Item	Due	Done X
➢ **Evidence of Insurability (EOI) Form** Required if you elect more than $300,000 coverage for yourself or more than $25,000 for your spouse (UNUM will email a link for the EOI application required for employee and/or spouse, if enrolled)	90 days from date of hire/eligibility*	☐

401(k) RETIREMENT PLAN

Employee participation (auto-enrollment) starts on next Entry Date: ***Oct 1, Jan 1, April 1, or July 1***

Access information about the 401(k) Retirement plan on the New Hires & Newly Eligible page on BellinBenefits.org

Your Date of Hire/Eligibility*: ____/____/____

If eligibility for benefits is not due to original date of hire, the date of eligibility (date of status change or life event) is used.

Calculate the dates your actions/items are due:

30 Days = ____/____/____ **90 Days =** ____/____/____

All forms and benefit information are available at BellinBenefits.org, New Hires & Newly Eligible page.
If you have questions, please email: employeebenefits@bellin.org or call Human Resource Management at (920) 445-7240

Rev. 11.23

Notice

All Benefit Plan documents, Summary of Benefit Coverage (SBC) and notices are available (electronically) on **BellinBenefits.org** under Legal/Plan Documents. You may also request a paper copy by contacting Human Resources.

Most benefit communications are sent via email to your Bellin email and your personal email (if provided). It is important to check your email regularly.

Bellin Health's Wellness Initiatives

As health care costs continue to rise, we strive to offer competitive health benefits to take care of you and your family. Staying up-to-date with preventive screenings is an important part of taking care of your health. Having regular screenings can result in serious medical conditions being discovered early. This allows treatment to begin before they become advanced, leading to better outcomes and lower treatment cost. A win for our employees and a step in the right direction to help manage rising health insurance costs.

In addition to enrollment, here are some other things you may need to complete and/or submit, and information about how you can earn a lower health and dental premiums.

This table (with links to information and forms) is available on the New Hires & Newly Eligible page on BellinBenefits.org.

More To Do if you Enroll in Benefits. Earn Lower Premiums!

In addition to enrollment, here are some other things you may need to complete and/or submit, and information about how you can earn a lower health and dental premium and PBA (HRA) or HSA funds from Bellin to offset out-of-pocket cost for medical coverage for the remainder of 2024 and 2025.

What (use links to see information/forms)	For Whom	When
BELLIN WELLNESS REWARDS PROGRAM INFORMATION **To qualify for the lowest health plan premium for the remainder of 2024*, complete the following:** • **Wellness Statement (showing you are up-to-date with preventive screenings)** **Note: All employees start in the highest cost premium, and are moved to the lowest premium level when their Wellness Statements are received.*	You and your spouse (if applicable), if enrolled on the health plan	90 days from the date of hire/date of eligibility
Required Form (if spouse enrolled on health plan): **Spouse Medical Insurance Statement**	Your spouse, if enrolled on the health plan	30 days from date of hire/date of eligibility
To qualify for lower dental plan premiums for the remainder of 2024:** **Dental Preventive Services form** ***Note: All employees start in the highest cost premium, and are moved to the lowest premium level when their Dental Preventive Services forms are received.*	You and your spouse (if applicable), if enrolled on the dental plan	90 days from date of hire/date of eligibility
Required documentation (if spouse, dependents enrolled on benefits): **Dependent Eligibility Requirement**	Your spouse and other dependents enrolled on the health, dental, vision and/or voluntary life insurance	30 days from date of hire/date of eligibility

HEALTH AND WELL-BEING RESOURCES

Bellin Health Coaches

- Free and confidential health coaching related to: nutrition, weight management, smoking cessation, exercise and improving work-life balance
- Care Coordination and Chronic Care Management services

More innformation available at Bellin Health Coaches page on BellinBenefits.org.

Medical

Bellin offers two medical plans, the Bellin First Health Plan and the Bellin High Deductible Health Plan. The charts on the following pages show a brief outline of each plan.

Please refer to the Medical page on BellinBenefits.org or the summary plan description (SPD) for complete plan details. The SPD and SBC (Summary of Benefit Coverage) for the plans are located under Plan Docs (or Legal/Plan Documents) on BellinBenefits.org.

Bellin First Health Plan

The Plan includes "Bellin First" coverage; visits and labs with your Bellin PCP and Bellin Urgent Care, Bellin Primary Care virtual visits, Bellin FastCare visits and Bellin PT visits (for rehabilitative care) are at no cost. The plan has a Health Reimbursement Account (HRA or PBA/HRA) that Bellin may contribute to (see information below).

PBA (HRA) Account (Provided by Bellin Health) to offset deductible/out of pocket costs *+Must be completed within 90 days of date of hire/date of eligibility*	Employee and Spouse (if enrolled) who complete their Wellness Statement+	Single: $400 Family: $800 *(Amount is prorated based on coverage effective date, if coverage does not start on January 1)*
	Employee and Spouse (if enrolled) who did not complete their Wellness Statement	NONE

Medical Plan Highlights	***HealthPartners, Inc. Bellin First Medical Plan 34601***		
Benefits Coverage	***In-Network Tier 1 (Bellin Health and ThedaCare ACO Network Providers, Froedtert and Children's Hospital)***	***In-Network Tier 2 (Aurora, UW Madison, Dickinson (DCH), Escanaba (OSF) and Cigna Wrap Providers)***	***Out-of-Network Tier 3***
Annual Deductible			
Individual	$2,250	$4,000	$5,000
Family	$4,500	$8,000	$10,000
Coinsurance	85% or 75%	60%	50%
Medical Out-of-Pocket			
Individual	$4,500	$5,300	$9,000
Family	$9,000	$10,600	$18,000
Separate Prescription Drug (RX) Out of Pocket Maximum-In addition to Medical Out of Pocket			
	$2,600 per person/$5,200 Family		N/A - Not Covered
Physician Office Visit			
Primary Care	**Bellin Primary Care: 100% coverage (visits and labs) no deductible.** All other Tier 1 Primary Care Providers: 85% coverage after deductible	60% after deductible	50% after deductible
Online Care/Virtual Visits (Primary Care only)	**Bellin E-Visits/Video Visit: 100% coverage, no deductible.** All other Tier 1: 85% coverage after deductible	60% after deductible	No Coverage

Medical Plan Highlights	*HealthPartners, Inc.* *Bellin First Medical Plan 34601*		
Benefits Coverage	*In-Network Tier 1 (Bellin Health and ThedaCare ACO Network Providers, Froedtert and Children's Hospital)*	*In-Network Tier 2 (Aurora, UW Madison, Dickinson (DCH), Escanaba (OSF) and Cigna Wrap Providers)*	*Out-of-Network Tier 3*
Specialty Care	75% after deductible	60% after deductible	50% after deductible
Preventive Care			
Routine Physical & Eye Examinations	100%	100%	50% after deductible
Routine Colonoscopy (outpatient) Includes scopes with polyp removal	100%	100%	50% after deductible
Prenatal, postnatal care++ and well child care *++First prenatal visit including labs/pregnancy test and first ultrasound paid at 100% with In-Network Provider. All other follows Office Visits and Out Patient Services.*	Follows coverage for Office Visits (Primary Care, and Specialty Care for OB-GYN), and Outpatient Services.	Follows coverage for Office Visits (Primary Care, and Specialty Care for OB-GYN), and Outpatient Services.	50% after deductible
Immunizations	100%	100%	50% after deductible
Diagnostic Services			
X-ray and Lab Tests	85% after deductible	60% after deductible	50% after deductible
Complex Radiology	85% after deductible	60% after deductible	50% after deductible
Urgent Care Facility	**Bellin Urgent Care: 100% (visits and labs) no deductible.** *Does not include Bellin Urgent Care at Oconto Hospital Medical Center which is covered like any other Tier 1 provider.* All other Tier 1: 85% after deductible	60% after deductible	50% after deductible
Emergency Room Facility Charges	85% after deductible	See Tier 1 coverage	See Tier 1 coverage
Convenience Clinics (Retail Clinic)	**Bellin FastCare: 100% coverage, no deductible.** All other Tier 1: 85% coverage after deductible.	60% after deductible	50% after deductible
Inpatient Facility Charges	85% after deductible	60% after deductible	50% after deductible
Outpatient Facility and Surgical Charges	85% after deductible	60% after deductible	50% after deductible
Mental Health			
Inpatient	85% after deductible	60% after deductible	50% after deductible
Outpatient	85% after deductible	60% after deductible	50% after deductible
Substance Abuse			
Inpatient	85% after deductible	60% after deductible	50% after deductible
Outpatient	85% after deductible	60% after deductible	50% after deductible

Medical Plan Highlights	*HealthPartners, Inc.* *Bellin First Medical Plan 34601*		
Benefits Coverage	*In-Network Tier 1 (Bellin Health and ThedaCare ACO Network Providers, Froedtert and Children's Hospital)*	*In-Network Tier 2 (Aurora, UW Madison, Dickinson (DCH), Escanaba (OSF) and Cigna Wrap Providers)*	*Out-of-Network Tier 3*
Other Services			
Physical and Occupational Therapy ***[1]Does not include habilitation services, which are covered the same as all other Tier 1.***	**Bellin PT/OT[1]: 100% coverage, no deductible (for rehabilitation sevices).** All other Tier 1: 75% after deductible	60% after deductible	50% after deductible
Chiropractic (neuromusculoskeletal conditions only)	75% after deductible	60% after deductible	50% after deductible
Retail Pharmacy (30 Day Supply)			
Generic Formulary	Tier 1 Pharmacy: $10 Copay at Bellin, Walmart and Meijer (Green Bay location only)	Tier 2 Pharmacy: $35 Copay at all In-Network Pharmacies	50% after deductible
Brand Formulary	Tier 1 Pharmacy: $30 copay or 35% whichever is greater up to a $165 maximum per script at Bellin, Walmart, Meijer (Green Bay location only).	Tier 2 Pharmacy: $80 copay or 40% whichever is greater, up to $200 max at all In-Network Pharmacies	50% after deductible
Preferred Specialty	$300 copay per prescription	$300 copay per prescription	Not covered
Mail Order Pharmacy (90 Day Supply)			
Generic Formulary	$25 copay	$25 copay	N/A
Brand Formulary	$75 copay or 35%, whichever is greater up to $495 max	$75 copay or 35%, whichever is greater up to $495 max	N/A

Bellin First Plan Employee Contributions - Monthly (Per Pay Period)

Premium A (Steps 1-3 of Annual Wellness Rewards Completed, except for New Hires**)		
Coverage Option	***Full-Time Rate (FT .8 to 1.0 FTE EEs)***	***Part-Time Rate (FT .5 to .7 FTE EEs)***
Employee	$129.35 ($ 59.70/pp)	$250.93 ($115.81/pp)
Employee + 1	$287.95 ($132.90/pp)	$558.43 ($257.74/pp)
Family	$350.64 ($161.83/pp)	$680.21 ($313.94/pp)
Premium B (Steps 1 and 2 of Annual Wellness Rewards Completed – does not apply to New Hires)		
Coverage Option	***Full-Time Rate (FT .8 to 1.0 FTE EEs)***	***Part-Time Rate (FT .5 to .7 FTE EEs)***
Employee	$171.02 ($ 78.93/pp)	$292.60 ($135.05/pp)
Employee & 1	$329.62 ($152.13/pp)	$600.10 ($276.97/pp)
Family	$392.31 ($181.07/pp)	$721.88 ($333.18/pp)
Premium C (Starting premium**, or Steps 1 and/or 2 of Annual Wellness Rewards Not Completed)		
Coverage Option	***Full-Time Rate (FT .8 to 1.0 FTE EEs)***	***Part-Time Rate (FT .5 to .7 FTE EEs)***
Employee	$301.48 ($139.14/pp)	$423.06 ($195.26/pp)
Employee & 1	$460.08 ($212.34/pp)	$730.56 ($337.18/pp)
Family	$522.77 ($241.28/pp)	$852.34 ($393.39/pp)

Contributions paid over 26 pay periods (pp) per year.

****New Hire and newly eligible employees start in Premium C and are moved to Premium A for remainder of the current plan year, if employee and spouse (if enrolled) complete a Wellness Statement showing they are up-to-date with preventive**

screenings within 90 days of date of hire/date of eligibility. Note: Premium level moves occur when the Wellness Statements are received and are not retro.

Spouse Medical Insurance Fee: If your spouse has other medical insurance coverage available through their employer, they must take at least single coverage through their employer to serve as primary coverage, or there is an additional fee ($100 per pay period) to enroll spouse in Bellin's medical coverage as primary coverage. See the Spouse Medical Insurance Coverage Statement at BellinBenefits.org. **This form is required if your spouse is enrolled in Bellin's Medical insurance.**

Bellin High Deductible Health Plan (HDHP)

HDHP Plan with Health Savings Account (HSA) administered by Empower. Employee may contribute to HSA and Bellin may make a contribution to the HSA (see information below).

HSA contribution provided by Bellin Health to offset deductible/out of pocket costs *+Must be completed within 90 days of date of hire/date of eligibility*	Employee and Spouse (if enrolled) who complete their Wellness Statement+	Single: $400 Family: $800 *(Amount is prorated based on coverage effective date, if coverage does not start on January 1)*
	Employee and Spouse who did not complete their Wellness Statement	NONE

Medical Plan Highlights	***HealthPartners, Inc.*** ***Bellin High Deductible Health Plan 34601***	
Benefits Coverage	***In-Network*** *(Bellin Health and ThedaCare ACO Network Providers, Froedtert and Children's Hospital, Aurora, UW Madison, Dickinson (DCH), Escanaba (OSF) and Cigna Wrap Providers)*	***Out-of-Network***
Annual Deductible		
Individual	$3,200	$6,200
Family	$6,000	$12,000
Coinsurance	85%	50%
Medical Out-of-Pocket		
Individual	$4,700	$9,000
Family	$9,000	$18,000
Physician Office Visit		
Primary Care	85% after deductible	50% after deductible
Specialty Care	85% after deductible	50% after deductible
Preventive Care		
Routine Physical & Eye Examinations	100%	50% after deductible
Routine Colonoscopy (outpatient) Includes scopes with polyp removal	100%	50% after deductible
Prenatal, postnatal care+ and well child care ***+First prenatal visit including labs/pregnancy test and first ultrasound paid at 100% with In-Network Provider. All other follows Office Visits and Out Patient Services.***	Follows coverage for Office Visits (Primary Care, and Specialty Care for OB-GYN), and Outpatient Services.	50% after deductible
Immunizations	100%	50% after deductible
Diagnostic Services		
X-ray and Lab Tests	85% after deductible	50% after deductible

Medical Plan Highlights	***HealthPartners, Inc.*** ***Bellin High Deductible Health Plan 34601***	
Benefits Coverage	***In-Network*** *(Bellin Health and ThedaCare ACO Network Providers, Froedtert and Children's Hospital, Aurora, UW Madison, Dickinson (DCH), Escanaba (OSF) and Cigna Wrap Providers)*	***Out-of-Network***
Complex Radiology	85% after deductible	50% after deductible
Urgent Care Facility	60% after deductible	50% after deductible
Emergency Room Facility Charges	85% after deductible	See Tier 1 coverage
Convenience Clinics (Retail Clinic)	85% after deductible	50% after deductible
Inpatient Facility Charges	85% after deductible	50% after deductible
Outpatient Facility and Surgical Charges	85% after deductible	50% after deductible
Mental Health		
Inpatient	85% after deductible	50% after deductible
Outpatient	85% after deductible	50% after deductible
Substance Abuse		
Inpatient	85% after deductible	50% after deductible
Outpatient	85% after deductible	50% after deductible
Other Services		
Physical and Occupational Therapy	85% after deductible	50% after deductible
Chiropractic (neuromusculoskeletal conditions only)	85% after deductible	50% after deductible
Retail Pharmacy (30 Day Supply)		
Generic Formulary	85% after deductible	Not covered
Brand Formulary	85% after deductible	Not covered
Preferred Specialty	85% after deductible	Not covered
Mail Order Pharmacy (90 Day Supply)		
Generic -Formulary	85% after deductible	N/A
Brand Formulary	85% after deductible	N/A
Preventive Drugs – HDHP Enhanced Preventive Drug List		
Enhanced Preventive Drug List *(View current HDHP (ACA) Preventive Drug List)*	100% coverage	50% coverage after deductible

Continued on next page

Bellin High Deductible Health Plan Employee Contributions - Monthly (Per Pay Period)		
Premium A *(Steps 1-3 of Annual Wellness Rewards Completed, except for New Hires**)*		
Coverage Option	***Full-Time Rate (FT .8 to 1.0 FTE EEs)***	***Part-Time Rate (FT .5 to .7 FTE EEs)***
Employee	$121.59 ($ 56.12/pp)	$235.88 ($108.87/pp)
Employee + 1	$270.67 ($124.92/pp)	$524.92 ($242.27/pp)
Family	$329.60 ($152.12pp)	$639.40 ($295.11/pp)
Premium B *(Steps 1 and 2 of Annual Wellness Rewards Completed – does not apply to New Hires)*		
Coverage Option	***Full-Time Rate (FT .8 to 1.0 FTE EEs)***	***Part-Time Rate (FT .5 to .7 FTE EEs)***
Employee	$163.26 ($ 75.35/pp)	$277.55 ($128.10/pp)
Employee & 1	$312.34 ($144.16/pp)	$566.59 ($261.50/pp)
Family	$371.27 ($171.36/pp)	$681.07 ($314.34/pp)
Premium C *(Starting premium**, or Steps 1 and/or 2 of Annual Wellness Rewards Not Completed)*		
Coverage Option	***Full-Time Rate (FT .8 to 1.0 FTE EEs)***	***Part-Time Rate (FT .5 to .7 FTE EEs)***
Employee	$293.72 ($135.56/pp)	$408.01 ($188.31/pp)
Employee & 1	$442.80 ($204.37/pp)	$697.05 ($321.72/pp)
Family	$501.73 ($231.57/pp)	$811.53 ($374.55/pp)

Contributions paid over 26 pay periods (pp) per year.

****New Hire and newly eligible employees start in Premium C and are moved to Premium A for remainder of the current plan year, if employee and spouse (if enrolled) complete a Wellness Statement showing they are up-to-date with preventive screenings within 90 days of date of hire/date of eligibility. Note: Premium level moves occur when the Wellness Statements are received and are not retro.**

HSA Funds: The Health Savings Account (HSA) is funded by Bellin and the employee. Employees earn HSA funds from Bellin by completing a Wellness Statement showing they are up-to-date with preventive screenings within 90 days of date of hire/date of eligibility. Spouse, if enrolled must also complete a Wellness Statement. You may also contribute to your HSA. The 2024 maximum HSA contributions (including Bellin contribution) is $4,150 for employee and $8,300 for employee + 1 or family plan enrollment. Employees age 55 or older may contribute an additional $1,000 (catch-up).

Spouse Medical Insurance Fee: If your spouse has other medical insurance coverage available through their employer, they must take at least single coverage through their employer to serve as primary coverage, or there is an additional fee ($100 per pay period) to enroll spouse in Bellin's medical coverage as primary coverage. See the Spouse Medical Insurance Coverage Statement at BellinBenefits.org. **This form is required if your spouse is enrolled in Bellin's Medical Insurance.**

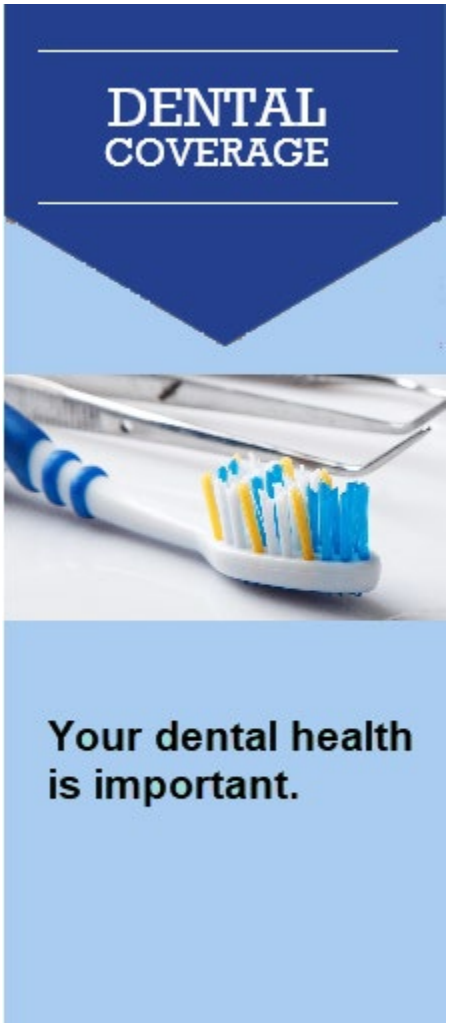
Additional Information

If enrolling in the HDHP Plan

- Employees age 65 or older may not be enrolled in Medicare
- Employees enrolled in Tricare (military coverage) may not enroll
- Employees/dependents may not have other health coverage that is not an HDHP
- Employees may enroll in Limited Flex Spend (FSA) to put aside pre-tax dollars for dental and vision expenses

Plan Comparison

A side by side comparison of the Bellin First Medical Plan and the High Deductible Health Plan is available on the Medical page on BellinBenefits.org.



Dental

Preventive/Diagnostic Care

- Exams: 2x a year
- Cleanings: 2x a year
- Routine X-rays: 1x each calendar year
- Fluoride Treatments: 1x a year for members under age 19.
- Sealants: 1 application per tooth once every three years

Major Care

- Posterior Composite (white) filings
- Caps and Crowns/Onlays
- Bridgework
- Dentures
- Implants-1x every five years.

Basic Care

- Fillings (amalgam and anterior composite)
- Root Canals
- Simple Extractions
- Oral Surgery
- Periodontics-Non-surgical and surgical periodontics limited to 1x every 2 years.

Orthodontic Care

Covered for Adults and Dependents (Deductible Waived)

Dental care is important to your overall health! Earn a lower premium by showing you have completed at least one preventive dental exam/cleaning. See Page 11 for more information.

The chart below is a brief outline of the plan. **Please refer to the summary plan description (SPD) located under Plan Docs (or Legal/Plan Documents) on BellinBenefits.org** for complete plan details. For more information about the dental plan see HealthPartners Link available at BellinBenefits.org or contact Member Services at 866-443-9352 (7am-6pm) Monday through Friday.

	HealthPartners, Inc. Dental Plan 34601DE	
Benefits Coverage	***In-Network Benefits-HealthPartners and Cigna Network***	***Out-of-Network Benefits****
Annual Deductible		
Individual	$75	$75
Family	$150	$150
Waived for Preventive Care	Yes	Yes
Annual Maximum-Combined In and Out of Network Providers		
Per Person	$1,000	$1,000
Amount Insurance pays		
Preventive **	100%	100%

	HealthPartners, Inc. Dental Plan 34601DE	
Benefits Coverage	***In-Network Benefits-HealthPartners and Cigna Network***	***Out-of-Network Benefits****
Basic	80%, after Deductible	80%, after Deductible
Major	50%, after Deductible	50%, after Deductible
Orthodontia		
Benefit Percentage	50%	50%
Adults	Covered	Covered
Dependent Child(ren)	Covered	Covered
Lifetime Maximum	$1,250	$1,250

*Out-of-Network Dentists: If your Out-of-Network Dentist charges more than the maximum allowable you may be responsible for the difference for the amounts denied. In-Network providers do not balance bill their patients for these amounts, please see a listing of In-network providers available online using the HealthPartners link at BellinBenefits.org.

**The cost for preventive services is applied to the max benefit amount.

Additional Periodontics services (exams, cleanings, scaling and root planings), for members who are diabetic and/or pregnant are covered at 100% for In-Network Providers.

Employee Contributions - Monthly (Per Pay Period)		
Dental Plan – Preventive Services Completed+		
Coverage Option	***Full-Time Rate (FT .8 to 1.0 FTE EEs)***	***Part-Time Rate (FT .5 to .7 FTE EEs)***
Employee	$10.94 ($ 5.05/pp)	$17.50 ($ 8.08/pp)
Employee & 1	$25.03 ($11.55/pp)	$40.04 ($18.48/pp)
Family	$31.05 ($14.33/pp)	$49.68 ($22.93/pp)
Dental Plan – Preventive Services Not Completed		
Coverage Option	***Full-Time Rate (FT .8 to 1.0 FTE EEs)***	***Part-Time Rate (FT .5 to .7 FTE EEs)***
Employee	$19.69 ($ 9.09/pp)	$26.25 ($12.12/pp)
Employee & 1	$45.05 ($20.79/pp)	$60.06 ($27.72/pp)
Family	$55.89 ($25.80/pp)	$74.51 ($34.39/pp)

+Preventive Service Completed: New hires and newly eligible employees and spouses may submit proof of Preventive Dental Services (exam and cleaning) done within the previous 12 months or within first 90 days after date of eligibility, and they will be moved to the lower dental premium for the remainder of the current calendar year. Preventive Dental Services Form is available at BellinBenefits.org. Note: Premium level moves occur when the Preventive Dental Services forms are received and are not retro.

Annually, employees/spouses that have completed at least one (1) preventive exam/cleaning during the year will pay a lower premium for the next calendar year. Preventive dental services will be reported annually by HealthPartners.

Note: If your Spouse has primary dental coverage through an employer and Bellin's dental plan is secondary coverage, they will need to submit a Preventive Dental Service Form annually by established deadlines.

See more information about the Dental Plan on the Dental page, BellinBenefits.org.

VISION COVERAGE

Two options available:

- **Exam + Materials**
- **Materials Only**

As a reminder, a basic vision exam is also covered annually under the health insurance plan.

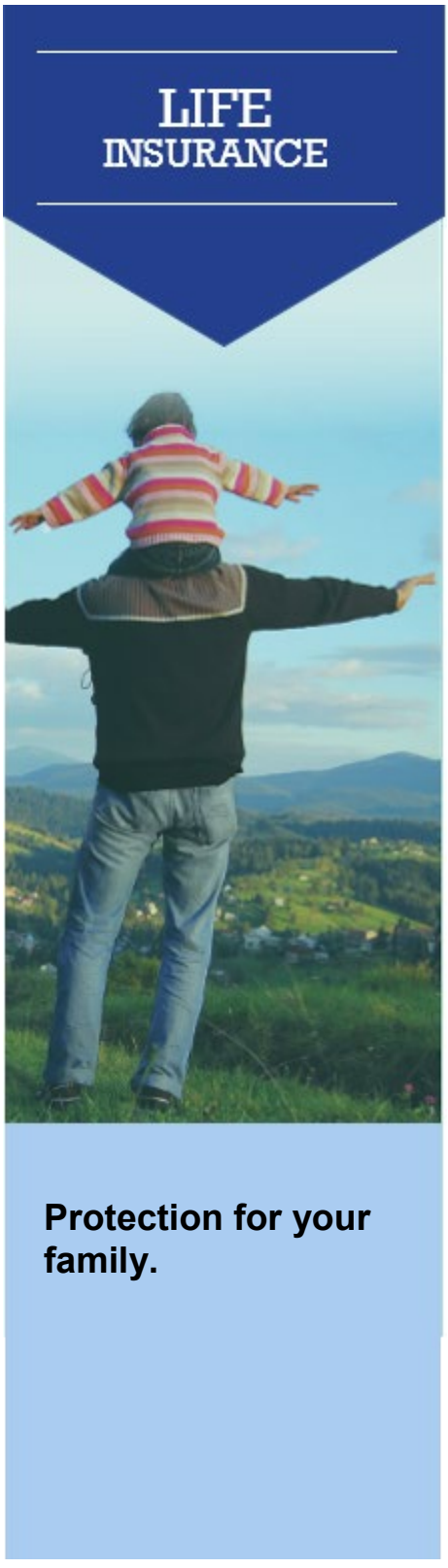
Vision

Bellin Health provides two Vision Insurance plans administered by MetLife Superior Vision.

Partial listing of coverage for services with in-network providers	**MetLife Full Service Plan**	**Metlife Materials Only -Lenses and Frames Plan**
Copay		
Routine Exams (Annual)	100% after $10 copay	Not covered
Vision Materials		
Lenses	100% after $10 copay* every calendar year **For standard glass or plastic. Benefit varies by lens type and options.*	100% after $10 copay* every calendar year **For standard glass or plastic. Benefit varies by lens type and options.*
Contacts, covered in lieu of frames. Medically necessary contacts may be covered at a higher benefit level.	Elective contacts covered up to $150 allowance plus 20% discount (Conventional), or 10% discount (Disposable,) off balance every calendar year • Standard fitting covered at 100% after copay $20 • Specialty fitting $50 allowance after $20 copay	Elective contacts covered up to $150 allowance plus 20% discount (Conventional), or 10% discount (Disposable,) off balance every calendar year • Standard fitting covered at 100% after copay $20 • Specialty fitting $50 allowance after $20 copay
Frames	Covered at up to $150 allowance plus 20% discount off balance every two calendar years	Covered at up to $150 allowance plus 20% discount off balance every two calendar years

Employee Contributions – Monthly (Per Pay Period)	
Vision – Full Service Plan	
Employee	$4.89 ($2.26/pp)
Employee & 1	$9.78 ($4.51/pp)
Family	$16.98 ($7.84/pp)
Vision – Materials Only Plan	
Employee	$4.27 ($1.97/pp)
Employee & 1	$8.54 ($3.94/pp)
Family	$14.82 ($6.84/pp)

See more information about the Vision Plans on the Vision page, BellinBenefits.org.



Life and AD&D

Bellin Health provides Basic Life and AD&D benefits to benefit eligible employees. The Life insurance benefit will be paid to your designated beneficiary in the event of death while covered under the plan. The AD&D benefit will be paid in the event of a loss of life or limb by accident while covered under the plan. Coverage begins on the first of the month after sixty (60) days from date of hire/date of eligibility.

Unum Life Insurance Company of America Life and AD&D	
You	
Benefit	Two times your annual salary ($200,000 max)
Your Spouse	
Benefit	Not covered
Your Child	
Benefit	Not covered

The above benefits will decrease by 50% at age 70.

Important Reminder!

Be sure to assign a beneficiary or living trust to ensure your assets are distributed according to your wishes.

Voluntary Life and AD &D

In addition to the employer paid Basic Life and AD&D coverage, you have the option to purchase additional voluntary life insurance to cover any gaps in your existing coverage that may be a result of age reduction schedules, cost of living, existing financial obligations, etc. In addition, you may also purchase coverage for your spouse and children. If you don't elect this benefit when you are first eligible, your election (and coverage for your spouse) made during Annual Open Enrollment, will be subject to medical questions and evidence of insurability.

If you purchase additional Life and AD&D insurance with Unum Life Insurance Company of America, your contributions will depend on your age and the amount of coverage you elect. In addition, you and/or your spouse may need to complete evidence of insurability if you elect coverage above the guarantee max.

Information about the basic life insurance, rates and guarantee max amounts for voluntary life insurance is available Life Insurance page on BellinBenefits.org.

DISABILITY COVERAGE

Disability insurance provides you with income protection in the event you are unable to work.

Short-Term Disability

Non-Exempt (Hourly) Employees

Bellin Health provides short-term disability coverage through Unum Life Insurance Company of America. This benefit covers 60% of your weekly base salary up to $2,500/week. The benefit begins after 7 days of injury or illness and can last up to 12 weeks. **More information about the plan is available on the Disability Page on BellinBenefis.org.**

Exempt Employees

Exempt employees accrue Extended Benefit Bank (EBB) hours instead of Short-Term Disability insurance. EBB is substituted in the event of extended illness or injury and EBB is paid at 75% of base salary.

Long-Term Disability

Exempt Employees

Bellin Health provides long-term disability insurance through Unum Life Insurance Company of America in the event you become unable to work due to a non-work related illness or injury. This benefit covers 60% of your monthly base salary up to $10,000/month. Benefit payments begin 90 days after the start of disability. Benefit duration varies. **More information about the plan is available on the Disability Page on BellinBenefis.org.**

Voluntary Long-Term Disability

Non-Exempt (Hourly) Employees

Bellin Health offers you the option to purchase long-term disability insurance through Unum Life Insurance Company of America. Employees may elect coverage up to 60% of base monthly earnings (max of $5,000 per month). In the event you become unable to work due to a non-work related illness or injury, benefit payments begin 90 days after the start of disability. Coverage duration varies. If coverage is not elected when you are first eligible, your election during annual open enrollment will be subject to medical questions and evidence of insurability.

See more information about the plan including rates on the Disability Page on BellinBenefis.org.

FLEXIBLE SPENDING ACCOUNT

Important Information:

- **Review how the plan works**
- **Only enroll if you know you'll have qualifying expenses**
- **Keep your receipts and EOBs to provide substantiation to WEX when requested**

Flexible Spending Accounts (Flex Spend)

The Flex Spend Account (FSA) plan with WEX (WEX Health, Inc.), allows you to set aside pre-tax dollars to cover qualified expenses you would normally pay out of your pocket with posttax dollars. The plan offers a health (medical) care or limited 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, pretax, 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 (health/limited FSA only) OR submit the appropriate paperwork to be reimbursed by the plan.

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.

Maximum Annual Election	
Health Care FSA (medical, dental and vision expenses), or Limited FSA (only dental and vision expenses)	$3,050 (per employee)
Dependent Care FSA (day care expenses)	$5,000 (per household)

++Up to $610 of unused Health/Limited FSA funds may be rolled over to the next plan year. This does not apply to the Dependent Care FSA.

See more information about the plan on the Flex page on BellinBenefits.org.

EMPLOYEE ASSISTANCE PROGRAM

Helpful resources for you and your family members at no cost.

Employee Supportive Services Program (LifeMatters)

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. LifeMatters, your Employee Supportive Services program is a problem-solving resource available to you and your household members. In addition, to counseling, the program also offers these other helpful resources:

- Financial Wellness Resources
- Legal Counseling/Legal Forms
- Work-Life Services (finding local resources for your needs)
- Articles/Information on many well-being topics

Counseling Services… 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... The program is provided by Empathia, Inc., 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 the program will appear in your personnel file.

24/7 Access… LifeMatters is only a phone call away at 800-634-6433 or go to **mylifematters.com and enter password: "BELLIN1".**

See more information about the program on the Employee Supportive Services page on BellinBenefits.org.

Changes in Benefit Elections

Annual Open Enrollment

With few exceptions, Annual Open Enrollment is the only time of year when you can make changes to your benefits plans. All elections and changes made take effect on the first day of the next plan year (January 1). 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.

Life Events

Enrollment changes may also be made within 30 days of experiencing a life event. Examples of qualifying life events include:

- Marriage
- Divorce
- Birth/Adoption
- Loss of other coverage
- Eligibility for other coverage

Information about how to submit enrollment changes due to a life event is available on the Life Events page on BellinBenefits.org.

Note: Some states (currently, California, Massachusetts, New Jersey, Rhode Island, Washington D.C., and Vermont) may impose a tax on residents who do not have health insurance coverage, subject to limited exceptions.

Retirement Plan (401k)

Bellin offers a 401(k) retirement plan to help you reach your retirement goals. Regular full-time, part-time and casual part-time employees may participate in the plan. You may make your own contributions to the plan, and Bellin offers base and matching contributions to help save even more

Your contributions:

You're eligible to make your own employee contributions to the Bellin Health 401(k) Retirement Plan at the first entrance date (October 1, January 1, April 1 or July 1) after you have been employed, provided you are 18 years of age or older and have been paid for working at least one hour.

Auto-enrollment: Bellin will auto-enroll you for a 4% salary deferral (contribution) to be effective the first pay period after your initial entry date. However, you can change this if you determine you would like to contribute a higher or lower deferral rate, based on what works best for your budget. Contributions can be made to either a pre-tax or after-tax (Roth) account, and you may increase or decrease your contributions at any time, up to the IRS limit. And, if you're age 50 or older, you can defer an additional catch-up contribution.

Bellin's contributions:

You will be eligible to begin receiving Bellin's Employer Base and Employer Matching contributions on the first entrance date after you are 21 years of age or older and have worked 1,000, and have completed one year of service.

- Base Contribution: Once eligible, Bellin will make an automatic base contribution equal to 3% of your pay each pay period, even if you don't make your own contributions to the account.

- Matching Contribution: Once eligible, Bellin will make annual match contributions for each plan year beginning October 1. The contribution will be a 50% march of employee's contributions up to the first 8%.

More information about the plan is available on the 401(k) page on BellinBenefits.org.

REQUIRED NOTIFICATIONS

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.

If you would like more information on WHCRA benefits, call HealthPartners Member Service at 866-443-9352.

NEWBORNS ACT DISCLOSURE - FEDERAL

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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.

NOTICE OF COBRA CONTINUATION RIGHTS

Initial COBRA Notice

The following NOTICE OF COBRA CONTINUATION RIGHTS is being provided to you because you are eligible, recently became eligible, or will become eligible for coverage under Bellin Health System's group health plan.

We are required to provide this notice, and your receiving this notice does not mean that you have health plan coverage. Employees may enroll in the health plan within 30 days of the date of hire/date of eligibility due to a change in status or life event, and annually during Open Enrollment.

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

If you have questions

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

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

Keep your Plan informed of address changes

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

Plan contact information

The name of the group health plan is:	Bellin Health System Medical Plan
The plan administrator is:	Bellin Health System 744 S. Webster Ave PO Box 23400 Green Bay, WI 54313-3400
Phone number:	(920) 445-7240

NOTICE OF PRIVACY PRACTICES

As required by the Privacy Rules promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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

This notice is provided to employees of Bellin who are covered by any of the following Bellin Health Plans: Employee Assistance Program (EAP), Health or Limited Flexible Spending Account Plans, and/or the Bellin Medical, Dental Plan and Vision Plan (hereinafter referred to as "Bellin Health Plans").

This notice describes the medical information practices of Bellin Health's group health plan ("Plan") and that of any third party assets in the administration of Plan claims.

Our Pledge Regarding The Privacy of Your Medical Information

Medical information about you and your health is personal. We are committed to protecting your medical information. This notice applies to all of the medical records we maintain in connection with any Bellin Health Plan. This notice explains ways in which we may use and disclose medical information about you in connection with a Bellin Health Plan. It also describes our obligations and your rights regarding the use and disclosure of medical information with respect to any Bellin Health Plan.

We are required by law to: keep medical information that identifies you private; provide you this notice of our legal duties and privacy practices with respect to your medical information; and follow the terms of the notice that is currently in effect.

In summary, this notice provides you with the following important information: how we may use and disclose your identifiable health information; your privacy rights in regard to your identifiable health information; and our obligations concerning the use and disclosure of your identifiable health information.

If you have questions about any part of this Notice or if you want more information about the privacy practices of the Bellin Health Plans, please submit your questions in writing to the Human Resources Department.

Bellin Health Human Resource Management Department
744 South Webster Avenue, PO Box 23400
Green Bay, Wisconsin 54305-3400
Phone: (920) 445-7240 / Fax: (920) 445-7249

How the Bellin Health Plans May Use or Disclose Your Health Information

The following categories describe the ways that the Bellin Health Plans may use and disclose your health information. For each category of uses and disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

1. Treatment. We may use or disclose medical information about you to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you.

2. Payment Functions. We may use or disclose health information about you to determine eligibility for plan benefits, obtain premiums, facilitate payment for the treatment and services you receive from health care providers, determine plan responsibility for benefits, to assist with the adjudication or subrogation of health claims and to coordinate benefits. For example, payment functions may include reviewing the medical necessity of health care services, determining whether a particular treatment is experimental or investigational, or determining whether a treatment is covered under your plan.

3. Health Care Operations. We may use and disclose health information about you to carry out necessary insurance-related activities. For example, such activities may include underwriting, premium rating and other activities relating to plan coverage; conducting quality assessment and improvement activities; disease management, submitting claims for stop-loss coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and business planning, management and general administration.

4. Required by Law. As required by law, we may use and disclose your health information. For example, we may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.

5. Public Health. As required by law, we may disclose your health information to public health authorities when necessary to prevent a serious threat to your health and safety, or the health and safety of the public. For example, for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. Any disclosure, however, would only be to someone able to help prevent the threat.

6. Health Oversight Activities. We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings related to oversight of the health plan or health care system.

7. Judicial and Administrative Proceedings. We may disclose your health information in the course of any administrative or judicial proceeding. For example, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

8. Law Enforcement. We may disclose your health information to a law enforcement official for purposes such as: identifying or locating a suspect, fugitive, material witness or missing person; complying with a court order or subpoena; about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; about a death we believe may be the result of criminal conduct; about criminal conduct at the hospital and in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description of location of the person who committed the crime; and other law enforcement purposes.

9. Coroners, Medical Examiners and Funeral Directors. We may disclose your health information to coroners, medical examiners and funeral directors. For example, this may be necessary to identify a deceased person or determine the cause of death.

10. Organ and Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues, as necessary.

11. Public Safety. We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public. For example, for purposes of: preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; reporting reactions to medications or problems with products; notifying people of recalls of products they may be using; notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and notifying appropriate government authorities if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by the law.

12. National Security. We may disclose your health information to authorized federal officials for military (intelligence and counterintelligence), national security, and government activities authorized by the law.

13. Military. If you are a member of the armed forces, we may release medical information about you as required by military command authorities.

14. Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your medical information to the correctional institution or law enforcement official.

15. Worker's Compensation. We may disclose your health information as necessary to comply with worker's compensation or similar laws. These laws provide for benefits for work-related injuries or illness.

16. Marketing. We may contact you to give you information about health-related benefits and services that may be of interest to you.

17. Disclosures to Plan Sponsors. We may disclose your health information to the sponsor of your group health plan, for purposes of administering benefits under the plan.

When Bellin Health Plans May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, we will not use or disclose your health information without written authorization from you. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer be able to use or disclose health information about you for the reasons covered by your written authorization, though we will be unable to take back any disclosures we have already made with your permission.

Statement of Your Health Information Rights

1. Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of your health information. The Bellin Health Plans are not required to agree to the restrictions that you request. If we cannot accommodate your request you will be notified in writing. If you would like to make a request for restrictions, you must submit your request in writing to: Bellin Health Human Resource Management Department, 744 South Webster Avenue, PO Box 23400, Green Bay, WI 54305-3400. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

2. Right to Request Confidential Communications. You have the right to receive your health information through a reasonable alternative means or at an alternative location, for example you can ask that we only contact you at work or by mail. To request confidential communications, you must submit your request in writing to the Bellin Health Human Resource Management Department, 744 South Webster Avenue, PO Box 23400, Green Bay, WI 54305-3400. We will accommodate all reasonable requests; however, we are not required to agree to your request. Your request must specify how or where you wish to be contacted. If we are unable to meet your request you will receive a written notice as to the reason.

3. Right to Inspect and Copy. You have the right to inspect and copy health information about you that may be used to make decisions about your plan benefits. To inspect and copy such information, you must submit your request in writing to: Bellin Health Human Resource Management Department, 744 South Webster Avenue, PO Box 23400, Green Bay, WI 54305-3400. If you request a copy of the information, we may charge you a reasonable fee to cover expenses associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

4. Right to Request Amendment. You have a right to request that the Bellin Health Plans amend your health information that you believe is incorrect or incomplete, as long as the information is kept by or for our Plan. We are not required to change your health information and if your request is denied, we will provide you with information about our denial and how you can disagree with the denial. To request an amendment, you must make your request in writing to: Bellin Health Human Resource Management Department, 744 South Webster Avenue, PO Box 23400, Green Bay, WI 54305-3400. You must also provide a reason for your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: is not a part of the medical information kept by or for the Plan; was not created by us, unless the person or entity that created the information is no longer available to make the amendment; is not part of the information which you would be permitted to inspect and copy; or is accurate and complete.

5. Right to Accounting of Disclosures. You have the right to receive a list or "accounting of disclosures" of your health information made by us, except that we do not have to account for disclosures made for purposes of payment functions or health care operations, or made to you. To request this accounting of disclosures, you must submit your request in writing to: Bellin Health Human Resource Management Department, 744 South Webster Avenue, PO Box 23400, Green Bay, WI 54305-3400. Your request should indicate in what form you want the list (for example, paper or electronic), and should specify a time period of up to six years and may not include dates before April 14, 2004. Bellin's Health Plans will provide one list per 12 month period free of charge; we may charge you for additional lists. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

6. Right to Paper Copy. You have a right to receive a paper copy of this Notice of Privacy Practices at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of this Notice, send your request in writing to: Bellin Health Human Resource Management Department, 744 South Webster Avenue, PO Box 23400, Green Bay, WI 54305-3400.

7. Right to Receive Notification of a Breach of Unsecured Health Information. You have a right to, and will receive, notification regarding any breaches of your unsecured health information.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, submit your request in writing to:

Bellin Health Human Resource Management Department
744 South Webster Avenue, PO Box 23400
Green Bay, Wisconsin 54305-3400
Phone: (920) 445-7240 / Fax: (920) 445-4249

Changes to this Notice of Privacy Practices
Bellin's Health Plans reserve the right to amend this Notice of Privacy Practices at any time in the future and to make the new Notice provisions effective for all health information that it maintains. We will promptly revise our Notice and distribute it to you whenever we make material changes to the Notice. Until such time, Bellin's Health Plans are required by law to comply with the current version of this Notice.

Complaints
If you believe your privacy rights have been violated, you may file a complaint about this Notice of Privacy Practices or about how we handle your health information with Bellin Human Resource Management Department or the Department of Health and Human Services. To file a complaint with the Plan, contact Bellin Health Human Resource Management Department, 744 South Webster Avenue, PO Box 23400, Green Bay, WI 54305-3400, (920) 445-7240.

Bellin's Health Plans will not retaliate against you in any way for filing a complaint. All complaints to Bellin's Health Plans must be submitted in writing.

Effective Date of This Notice: September 19, 2023

NOTICE REGARDING WELLNESS PROGRAMS

Bellin Wellness Rewards is a voluntary wellness program available to all eligible employees and their spouses (if enrolled on the Health Plan). The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you and your spouse (if enrolled) will be asked to:

- Show that you are up to date with the preventive screenings shown on the Bellin Wellness Statement within 90 days of date of hire/date of eligibility. These screenings are covered by the Health Plans and paid at 100% with In-Network Providers. Wellness Statements may also be completed by previous health care providers if employee/spouse is up to date with preventive screenings at the time they become eligible for coverage. The Wellness Statement is available at BellinBenefits.org.

You and your spouse are not required to complete the preventive screenings on the Wellness Statement. Employees and spouses who choose to participate in the Bellin Wellness Rewards program and show they are up-to-date with preventive screenings within 90 days of date of hire/date of eligibility will qualify for the lowest premium and funds from Bellin to offset costs applied to the annual deductible for the remainder of the current year.

The Bellin Wellness Rewards program is an annual program and employees and spouses enrolled on the plan may participate by showing they are up-to-date with preventive screenings annually using a Wellness Statement or the Consent Form process by the yearend deadline established by Human Resources to qualify for a the lowest premium for the next plan year.

If you are unable to participate in the wellness program or achieve any of the health outcomes required to qualify for a lower premium or funds from Bellin to offset deductible cost, you may be entitled to a reasonable accommodation. You may request a reasonable accommodation by contacting Human Resource Management Department.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although we may use aggregate information the vendor collects to design a program based on identified health risks in the workplace, HealthPartners Wellbeing will never disclose any of your personal information of your personal information either publicly or to the Bellin, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is your Bellin Provider's Care Team in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the

wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact:

Bellin Health Human Resource Management Department
744 South Webster Avenue, PO Box 23400
Green Bay, Wisconsin 54305-3400
Phone: (920) 445-7240 / Fax: (920) 445-7249

Medicare Part D Notice

Important Notice from Bellin Health System 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 Bellin Health System 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. **Bellin Health System has determined that the prescription drug coverage offered by the Bellin Health System 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 15thto 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. OMB 0938-0990

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 Bellin Health System coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Bellin Health System coverage, be aware that you and your dependents may not be able to get this coverage back.

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

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 Bellin Health 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 Bellin Health System, Human Resource Management at (920) 445-7240

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 Bellin Health System changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Date:	September 27, 2022
Name of Entity/Sender:	Bellin Health System
Contact--Position/Office:	Human Resource Management
Address:	PO Box 23400 Green Bay, WI 54305-3400
Phone Number:	(920) 445-7240

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

Children's Health Insurance Program (CHIP)

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	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	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 (Hawki)	**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://kidshealth.ky.gov/Pages/index.aspx 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/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
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**
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 July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

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)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 9-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

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

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Bellin Health Human Resource Management, Benefits Team at (920) 445-7240.

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

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

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 Bellin Health Systems, Inc.		4. Employer Identification Number (EIN) 39-0884478
5. Employer address 744 S. Webster Ave, PO Box 23400		6. Employer phone number (920) 445-7240
7. City Green Bay	8. State WI	9. ZIP code 54305-3400
10. Who can we contact about employee health coverage at this job? Benefits Team, Human Resource Management		
11. Phone number (if different from above) (920) 445-7240, Option 3	12. Email address employeebenefits@bellin.org	

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

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

Regular part-time and full-time employees working 20 hours per week or more (.5 - 1.0 FTE)

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Legal spouse, natural child, legally adopted child, step child, court ordered support of a child and legal guardianship or disabled child. Proof of eligibility is required.

☐ 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.

CONTACT INFORMATION

Questions regarding any of this information can be directed to:
Bellin Health Human Resource Management Department
744 South Webster Avenue,
PO Box 23400
Green Bay, Wisconsin 54305-3400
Phone: (920) 445-7240
Fax: (920) 445-7249

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