

PRICE COUNTY
WISCONSIN



2026 | All Employees
Benefits Guide

Your Benefits, Your Choice

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Disclaimer: The information described within this guide is only intended to be a summary of your benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description for a complete explanation of your benefits. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail. You can obtain a copy of the Summary Plan Description from the Human Resources Department.

Welcome!

We understand that your life extends beyond the workplace. That’s why we offer a variety of benefits to help you be an advocate of your health and well-being. Our goal is to provide choices for you and your family to be appropriately covered through all stages of life.

We encourage you to read this guide, share it with your family members, and ask any questions you may have.

When to Enroll

Current Employees: Open Enrollment, which usually occurs between early November and late November, is your once-a-year opportunity to adjust benefit coverages and update any dependents and beneficiaries.

New Hires: Once eligible, you must complete your enrollment within 30 days. Some benefits have “guarantee issue” at your first opportunity only, so please carefully consider this before you decline any coverages.



Enroll Online through Employee Navigator

<https://www.employeenavigator.com/benefits/Account/Login>

Type the link into your web browser or scan the QR code using your smartphone device.

When to Make Changes

Unless you experience a qualifying life event, you cannot make changes to your benefits until the next open enrollment period. An election change must be made within 30 days of the qualifying event.

Qualifying life events include:

- Marriage, divorce, legal separation or death of a spouse
- Birth or adoption of a child
- Change in child’s dependent status
- Death of a spouse, child or other qualified dependent
- Change in residence
- Change in employment status or a change in coverage under another employer-sponsored plan

Questions? Contact HR



Medicare Part D Notice: If you or your dependents are on Medicare or will be eligible within 12 months, federal law offers more prescription drug coverage options. Refer to page 32 for details.



Contacts

Benefit Contact	Phone	Email
Jennifer Miller	715-339-5131	jennifer.miller@pricecounty.wi.gov
Laura Palzkill	715-339-5134	laura.palzkill@pricecounty.wi.gov

Benefits Enrollment	
Employee Navigator	http://employeenavigator.com/benefits/Account/Login

Coverage	Carrier	Phone Number	Website/Email
Medical Insurance	WPS	888-950-0060	www.wpshealth.com
Prior Authorization	WPS	888-950-0060	www.wpshealth.com
Telemedicine	Teladoc	800-TELADOC	www.teladoc.com
Dental Insurance	Ameritas	800-487-5553	www.ameritas.com
Vision Insurance	Ameritas/EyeMed	866-289-0614	www.eyemedvisioncare.com
Care Navigation	MyAdvocate360		
Weight Loss Support	Betr		https://betrhealth.com/pages/price-county
Health Savings Account	Associated Bank	920-327-6546	ParticipantServices@AssociatedBank.com
Mental Health Support	BetterHelp		www.betterhelp.com

Eligibility

Employee Eligibility

All full-time employees working 25 or more hours per week will be eligible for benefits. As a new employee, you have 30 days from your initial start date to enroll in benefits.

- **Medical, Dental, Vision:** Medical, Dental, and Vision coverages will take effect on the first of the month following 30 days of employment.

***IMPORTANT:** These benefits may require employees to be actively at work at the time benefits become effective. Please review policy documents, or contact HR, for additional information.

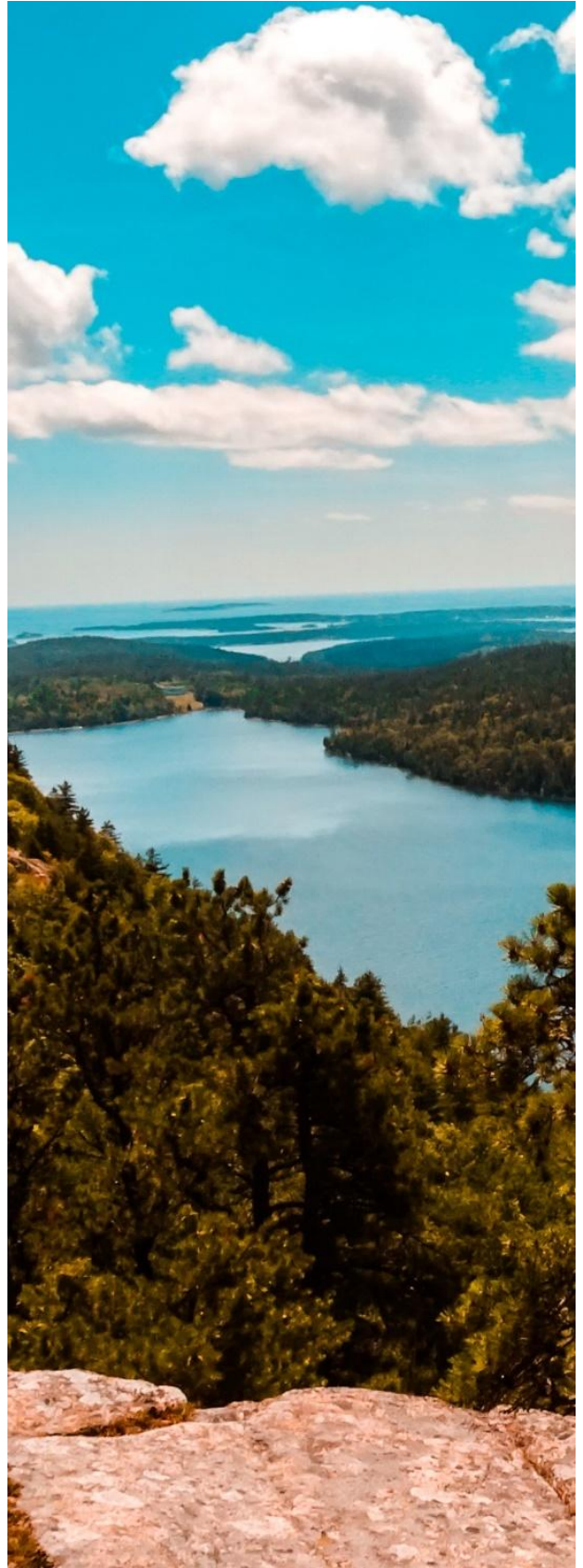
Dependent Eligibility

- **Medical, Dental, Vision:** Employees enrolled in Medical, Dental, and Vision coverages also have the option to enroll their Dependent Spouse and Dependent Children on these plans. See below for a definition of an “eligible dependent” under these plans.

Definition of “Eligible Dependents”

The below definitions refer to **Medical, Dental, and Vision Coverages**.

- **Your legally married spouse.** Such spouse must have met all requirements of a valid marriage contract of the State in which the marriage of such parties was performed. For the purposes of this definition, “spouse” shall not mean a common law spouse or domestic partner.
- **Your dependent children** until the end of the month, in which they attain age 26, legally adopted children from the date the employee assumes legal responsibility, foster children that live with the employee and for whom the employee is the primary source of financial support, children for whom the employee assumes legal guardianship and stepchildren.
- Also included are the employee’s children (or children of the employee’s spouse) for whom the employee has legal responsibility resulting from a valid court decree.
- Children who are mentally or physically disabled and totally dependent on the employee for support, past the age of 26 or older. To be eligible for continued coverage past the age of 26, certification of the disability is required within 31 days of attainment of age 26. A certification form is available from the employer or from the claims administrator and may be required periodically. You must notify the claims administrator and/or the employer if the dependent’s marital or tax exemption status changes and they are no longer eligible for continued coverage.



Monthly Employee Contributions

If you elect coverage, your premiums will be conveniently deducted from your paycheck. Please contact Human Resources regarding any questions or concerns.

Medical	Employee Cost	County HSA Annual Contribution
Premium Plus Plan		
Employee Only	\$120	\$0
Family	\$320	\$0
NEW – HSA Choice Care Plan		
Employee Only	\$51	\$600
Family	\$150	\$1,800

*Contribution is prorated for part-time eligible employees, see HR for part-time contribution rates.

Dental	Low Plan Employee Cost	High Plan Employee Cost
Employee Only	\$17.94	\$42.18
Employee + 1	\$33.96	\$88.12
Family	\$55.58	\$143.84

Vision	Employee Cost
Employee Only	\$5.58
Employee + 1	\$9.66
Family	\$13.98



Medical

WPS Statewide – Premium Plus Plan

This coverage allows you to visit any doctor or facility you choose—however, you will get the best coverage when you choose an in-network provider.

Medical	In-Network	Out-of-Network
Annual Deductible		
Individual	\$1,700	\$7,500
Family	\$3,400	\$15,000
Coinsurance		
Plan Pays	100%	60%
You Pay	0%	40%
Annual Out-of-Pocket Maximum		
Individual	\$2,000	\$15,000
Family	\$4,000	\$30,000
Services	In-Network	Out-of-Network
Preventive Care	100%	40% after deductible
Primary Care Office Visit	0% after deductible	40% after deductible
Specialist Office Visit	0% after deductible	40% after deductible
Urgent Care	0% after deductible	40% after deductible
Emergency Room	Deductible + \$150 copay (waived if admitted)	Deductible + \$150 copay (waived if admitted)
Hospitalization	0% after deductible	40% after deductible
Prescription Drugs	In-Network	Out-of-Network
Tier 1	0% after deductible	Not Covered
Tier 2	0% after deductible	Not Covered
Tier 3	0% after deductible	Not Covered

Specialty medications are accessed through the NaviCareRX program. Members can contact their dedicated Patient Care Coordinator at 877-371-3351 for assistance with acquiring specialty medications.

Please review the full plan documents for details. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

Medical

WPS Statewide – HSA Choice Care Plan

This coverage allows you to visit any doctor or facility you choose—however, you will get the best coverage when you choose an in-network provider.

Medical	In-Network	Out-of-Network
Annual Deductible		
Individual	\$3,500	\$7,500
Family	\$7,000	\$15,000
Coinsurance		
Plan Pays	80%	60%
You Pay	20%	40%
Annual Out-of-Pocket Maximum		
Individual	\$5,000	\$15,000
Family	\$10,000	\$30,000
Services	In-Network	Out-of-Network
Preventive Care	100%	40% after deductible
Primary Care Office Visit	20% after deductible	40% after deductible
Specialist Office Visit	20% after deductible	40% after deductible
Urgent Care	20% after deductible	40% after deductible
Emergency Room	20% after deductible	20% after deductible
Hospitalization	20% after deductible	40% after deductible
Prescription Drugs	In-Network	Out-of-Network
Tier 1	20% after deductible	Not Covered
Tier 2	20% after deductible	Not Covered
Tier 3	20% after deductible	Not Covered

Specialty medications are accessed through the NaviCareRx program. Members can contact their dedicated Patient Care Coordinator at 877-371-3351 for assistance with acquiring specialty medications.

Please review the full plan documents for details. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

Member Portal

The MedOne Member Portal allows you to access all pertinent information regarding your pharmacy benefit anytime, anywhere.

To access the Member Portal, go to www.medone-rx.com and click on MEMBER PORTAL. The MedOne Member Portal allows you to access everything you need concerning your pharmacy benefits, including:

- View Claims Details & Rx History
- Look Up In-Network Pharmacies in your area
- Obtain Pricing for your Medications
- Review Out of Pocket Maximum
- Access Drug Information Directory
- Gather ID Card Processing Information
- Enroll in MedOne Mail Order

Frequently Asked Questions

Is my drug on the MedOne formulary?

MedOne's drug look-up tool allows you to view medications that are on your formulary along with formulary alternatives.

- Go to medone-rx.com/members/drug-lookup
- Enter in the Rx GROUP ID (located on your ID Card)
- If you are currently taking one of the non-covered medications, please contact your physician and request a new prescription for one of the covered alternatives to be filled on or after your plan effective date.
- If you or your physician have questions about a medication or available alternatives, please call MedOne for assistance.

Will I need a prior authorization for my medication?

Your prescription benefit plan may include clinical programs and plan edits for specific medications or therapy classes. Prior authorization (otherwise known as pre-approval) may be needed to ensure safe and effective medication therapies are provided while keeping healthcare costs low for you and the plan. In some cases, certain medications may not be covered under your plan and lower-costing equivalent or alternative medications are made available.

We encourage you or your pharmacist to call MedOne at [866-335-9057](tel:866-335-9057) if you are prescribed a new medication in order to determine coverage status.

medone
Pharmacy
Benefit
Solutions



Member
Website

SCAN HERE

What do I do if I have issues filling my prescription on or after the plan effective date?

Your plan has chosen programs and edits on select medications or therapy classes, however a rejection at the pharmacy does not necessarily mean your medication is not covered. Rather, your medication may be subject to review and approval. If your pharmacist advises there is an issue, please ask them to call MedOne at [866-335-9057](tel:866-335-9057) to speak to one of our Member Advocates. Our Member Advocates will work quickly to resolve any issues. This number is also located on your Prescription ID card.

How do I go about filling my specialty medication?

Specialty medications are managed through the NaviCareRx program. Members can reach their dedicated Patient Care Coordinator at [877-371-3351](tel:877-371-3351) for assistance with acquiring specialty medications.





ADDITIONAL PLAN INFORMATION

MEMBER ID CARD

Members will receive a combined Medical/Prescription Benefit ID card from the medical administrator. This ID card contains important information the pharmacy needs in order to process prescriptions.

PremierONE PHARMACY NETWORK

The plan includes a network of pharmacies locally and nationwide. Register at www.MedOne-rx.com to search for an in-network pharmacy or call MedOne at **1-866-335-9057** for assistance.

MEDONE DRUG LOOK-UP TOOL

MedOne's drug look-up tool allows you to view medications that are on your formulary along with formulary alternatives. Go to medone-rx.com/members/drug-lookup to access this tool and enter in **MRPA2CTBRL** when prompted. If you or your physician has questions about a medication or available alternatives, please call MedOne at **1-866-335-9057**.

MEDONE MAIL-ORDER

For assistance in setting up a mail-order account, register at www.MedOne-rx.com or call MedOne at **1-866-335-9057** for assistance. Please allow 14 business days from the time the mail-order request is submitted until the prescription is delivered.

DISPENSE AS WRITTEN PENALTY

If a member requests a brand drug when a generic drug is available, the member is responsible for the applicable cost shares plus the difference in cost between the generic and brand drug.

REFILL-TOO-SOON LIMITATION

A prescription may not be refilled until at least 75% of a 30-day supply (or 60% of a 90-day supply) has been utilized. For example, 23 days of a 30-day supply must be utilized before the pharmacy is able to process another fill.

STEP THERAPY PROGRAM

This program ensures that members receive the most cost-effective medications prior to the plan approving brand medications. For the most current step therapy program information, register at www.MedOne-rx.com.

INFUSION CARE PATH SERVICES

MedOne offers the opportunities to fill infusion-based medications in an at home setting. Services are available at a reduced cost share. Plan deductibles may apply.

ACA COVERED PRESCRIPTIONS-\$0 COPAY

- Bowel Preparation limited to 1 per year
- Breast Cancer Chemo Prevention; prior authorization may be required
- Contraceptives up to a 91-day supply (depending on packaging)
- Smoking Cessation (Prescription and over-the-counter products with a prescription; prior authorization required)
- Vaccinations - Influenza, Herpes Zoster Shingles (age 60+), HPV, Pneumococcal, and COVID-19
- Statins for primary prevention of CVD - select low to moderate dose statins included for high-risk patients between ages 40 – 75
- HIV Preventatives; prior authorization required
- Vitamins & Minerals: Fluoride (age 6mo-5yr), Folic Acid, Iron Supplements, Vitamin D2, D3 Calcium (age ≥65)



Meet CANARX — The Simple, Safe & Smart Way to Save on Prescription Medications

WHO WE ARE

No Copay. No Catch.

Just Better Health.

Since 2002, **CANARX** has helped public and private-sector employees access brand-name maintenance medications at **zero cost to them**.

Recognized as the **Gold Standard**, **CANARX** offers a no-cost international mail-order program that **integrates with existing coverage** and delivers significant savings for both plans and members.

SAFETY IS NON-NEGOTIABLE

Our licensed pharmacies are regularly inspected. Every medication is dispensed by a pharmacist and overseen by our internal Quality Assurance Team. We only facilitate eligible, brand-name maintenance prescriptions—never narcotics, generics or temperature-sensitive meds—to maintain the highest safety and transparency standards.

WHAT WE DO

We contract with government-licensed pharmacies in Canada, the United Kingdom, and Australia (designated as Tier 1 countries by Congress). Medications arrive **direct to your mailbox**, sealed in their original packaging—no waiting in line at the pharmacy.

- ✓ \$0 Copay
- ✓ 300+ **Free** Brand-Name Medications
- ✓ Easy Online Refills
- ✓ No Additional Costs
- ✓ Fully Insured

A PROVEN TRACK RECORD

We've saved millions for self-funded plans across the U.S. since launching our first program in Springfield, MA.

From school boards to municipalities to private businesses, **CANARX** continues to offer a trusted solution built on 20+ years of experience.

READY TO LEARN MORE?

VISIT CANARX.COM OR CALL 1-866-893-6337





INTERNATIONAL PRESCRIPTION SOURCING

MedOne's Network of International Pharmacies

Overview

As health care costs as a whole continue to rise, prescription costs are no exception. The United States spends 30-190% more on prescription drugs than other countries. Through MedOne's NaviCareRx suite of specialty cost containment solutions, we collaborate with a network of international pharmacies to offer you alternative sourcing options for obtaining prescription medications at reduced prices.



How It Works

MedOne identifies members - like you! - taking medications eligible for international sourcing. MedOne's team of patient care coordinators will then reach out alerting you of the saving opportunities available, should you choose to shift your prescription to an international pharmacy.

Program Enrollment

NaviCareRx Patient Care Coordinators assist you throughout the enrollment process. Even after enrollment is complete, the Patient Care Coordinators follow up with you regularly to ensure satisfaction & troubleshoot any issues. MedOne Patient Care Coordinators can be reached by phone at **877-371-3351** or email at CareTeam@NaviCareRx.com.

About International Sourcing

Our international network sources medications from pharmacies in Australia, Canada, New Zealand, and the United Kingdom. These countries are classed as Tier One countries (designated by the US Congress) for pharmaceutical supply. All prescription drugs are from certified manufacturing plants that follow regulated manufacturing practices. Due to proximity, any temperature-sensitive medication will be sourced exclusively from Canada.

NAVICARE_{RX}



Near Site Clinic

Taylor Family Care Clinic-Locations in Phillips and Medford

Services provided at Taylor Family Care Clinic are at no cost to you!

- Get help with direct primary care, preventative care, chronic conditions management, and more!
- See a doctor the same or next business day for acute conditions.
- Walk-ins available!
- 70-80% of your needs can be addressed at the clinic.
- **New-Receive a \$125/employee and \$125/spouse (if enrolled on the medical plan) Taylor HSA Bonus for getting your physical completed at Taylor Family Care Clinic**

Get an annual physical at Taylor Family Care Clinic

- **Receive \$125 Taylor HSA Bonus per employee and spouse.**
- Physical must be scheduled between 1/1 and 11/30.
- Turn in your Taylor Care Clinic Form to HR
- Bonus payments will be paid in April, July, October and December.

Care Navigation

myAdvocate 360

Have Healthcare Questions? Your Advocate Can Help.

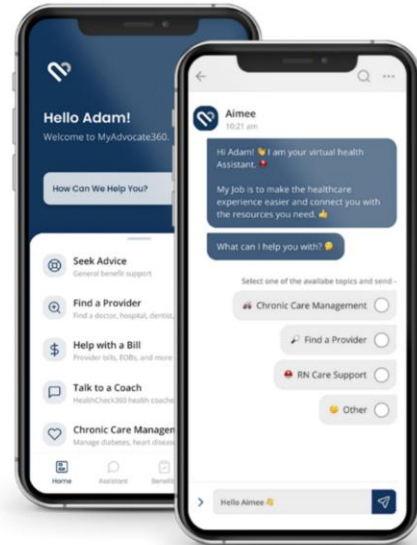
Get fast, reliable answers to all your healthcare questions with HealthCheck360's advocacy service. With your employee benefits plan, you have direct access to a real person who can help you understand and use your healthcare benefits with confidence.

Connect With an Advocate Today

Monday–Thursday from 7 a.m.–7 p.m. (CST)









Friday from 7 a.m.–5 p.m. (CST)

- **Call:** (855) 703-2215
- **Email:** myAdvocate@healthcheck360.com
- **Chat:** Start a chat in the app



Healthcare Can Be Complex. We Make It Easier.

You don't have to decode healthcare on your own. Quickly connect with an advocate who can help you understand your options and use your benefits with confidence.

 <p>Expert Advocates Available by Phone, Email, or Chat</p>	 <p>Easy Access to Your Benefit Details in the App</p>	 <p>Answers to All Your Benefits Questions</p>	 <p>Voluntary Health Coaching</p>
 <p>Support for Family Members</p>	 <p>Open Enrollment Education</p>	 <p>Assistance Finding In-Network Doctors</p>	 <p>Help with Claims & Billing Questions</p>



Introducing Advocacy with HealthCheck360!

As a Price County health plan member, you will soon have access to HealthCheck360—a patient advocacy service to help you navigate complex healthcare questions. This benefit will be available starting January 1, 2026.

Save on Elective Procedures!

Procedure costs can vary widely between providers—even within the same community. That’s why Price County and HealthCheck360 are partnering to offer members on Price County Health Plan a unique opportunity:

- Use the HealthCheck360 cost comparison tool to find lower-cost, high-quality providers.
- Earn an incentive **25% of the savings** (capped at **\$5,000 per member per year**).



Cost Savings

Significantly reduce your healthcare expenses with a personal guide to informed decision-making.



Quick Responses

Get your questions answered from a knowledgeable person, typically within 15 seconds.



Convenience

All your benefit details, insurance card information, provider directories, and one-on-one support in one place.



Rewards

You could receive a paycheck bonus for **25%** of the savings you earn from participating in the program!

Call an advocate for help with easily managing your benefits:

- ✓ *Check your deductible, coinsurance, co-pay, and out-of-pocket maximum.*
- ✓ *Get help with claims and billing questions.*
- ✓ *See pricing for upcoming procedures or imaging.*
- ✓ *View your insurance cards and benefits enrollment details.*

(855) 703-2215 | myadvocate360@healthcheck360.com | M - Th 7 a.m.-7 p.m. Fr 7 a.m. - 5 p.m. (CST)



Evaluate Healthcare Costs With Confidence

Let's say you find out you need a medical procedure. Did you know that the cost and quality of that procedure can vary widely between providers, even within the same community?

Example:

Grace needs a preventative colonoscopy completed. She calls an advocate and requests a cost comparison for facilities near her.

She receives the following information:

- **Hospital A** = \$6,156
- **Hospital B** = \$4,845
- **Endoscopy Center** = \$2,376

Grace completes her colonoscopy at the endoscopy center and sends the EOB after the procedure. In return, she receives a \$617 payroll check for participating in the program and selecting the most cost-effective option.

Nationwide Medical Care Ranges

	<i>Low Cost</i>	<i>High Cost</i>
Colonoscopy	\$950	\$8,550
MRI	\$324	\$7,300
CT Scan	\$200	\$7,800
Ultrasound	\$95	\$2,600
X-ray	\$80	\$1,200
Knee Surgery	\$6,961	\$31,750



With advocacy services, you don't have to navigate complex healthcare questions alone.

Get in Touch Today

Monday–Thursday from 7 a.m.–7 p.m. (CST)

Friday from 7 a.m.–5 p.m. (CST)

Call: (855) 703-2215

Email: myadvocate360@healthcheck360.com

Telemedicine

Teladoc

For more information visit www.teladoc.com or call 800-TELADOC.

Telemedicine can be a great alternative to visiting your normal doctor or an urgent care, when you are suffering from one of many common, non-emergency medical conditions. Using your computer, tablet or smartphone device, you can conveniently access to U.S. board-certified doctors and licensed professionals from the comfort of your home or wherever you happen to be.

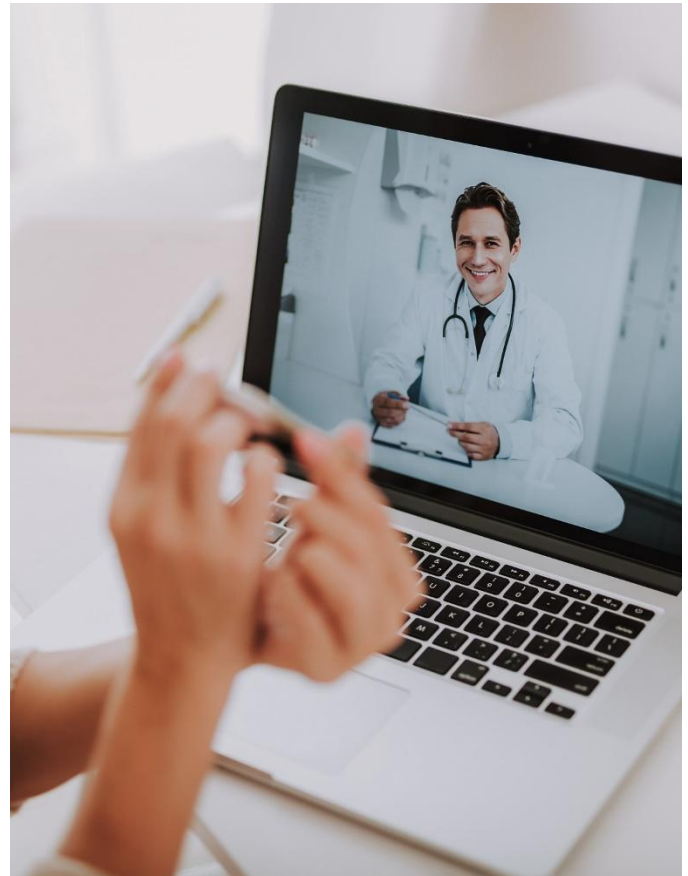
In some cases, doctors can write a prescription to a local pharmacy near you.*

Telemedicine	
Medical Visit	General Medical - \$0 Copay
Commonly Treated Medical Conditions	Allergies Pink eye
	Colds and flu Urinary tract infections
	Ear infections And more!
	Sore throat
Benefit Cost	Included with Medical coverage

When can I use telemedicine?

- When you need care now.
- If you're considering the ER or urgent care center for a non-emergency issue.
- On vacation, on a business trip, or away from home.
- For short-term prescription refills.

*Prescription services may not be available in all states.



Save time and money with telemedicine.

Telemedicine can provide significant savings over urgent care and emergency room visits. On top of that, you can connect with a doctor from the convenience of home or work, allowing you to avoid the hassle of traveling or sitting in a waiting room.

Federal Benefits Advocacy

FEDlogic

Your Very Own Personal Navigator

Price County. has partnered with FEDlogic to provide state and federal benefits information and advocacy to you and your household members. This service is confidential, unlimited, and free to all members and their families weather enrolled in benefits or not.

Below is a partial list of categories FEDLogic can assist with...

- Medicare
- Medicaid
- Disability
- Social Security Retirement
- Child Benefits
- Widow Benefits
- Supplemental Security Income (SSI)
- Veterans Benefits
- Healthcare.gov (COBRA alternatives)
- ESRD (End Stage Renal Disease)
- ALS (Lou Gehrig's Disease)
- Cancer or Terminal Illness

When You Need Us, It's All About You

We're passionate about providing highly personalized, easy, and practical phone consultation guidance to individuals and families. We never promote, endorse, or sell any type of product or insurance.



Contact

- 877-837-4196
- fedlogicgroup.com
- services@fedlogicgroup.com



Here's How it Works

Make a phone consultation appointment

Call us at 877-837-4196 to schedule a phone consultation appointment with one of our federal and state benefits experts. Be sure to make the appointment at a time when family members are available to listen and ask questions. Calls typically last an hour.

①

Tell us your story, ask questions and learn

You don't have to wade through tons of complex and confusing information to try to figure out what applies to you. We take the time to listen to your story and understand your needs, concerns, and goals. Then we empower you with the unbiased information you need so you can maximize your benefits and make the best decision for your situation.

②

Enroll for benefits

Once you feel confident you have the information you need to make the best decision for you and your family, we'll walk you through the application and approval process.

③

Relax and celebrate

Without education and advocacy, many people don't tap into all the Social Security and Medicare benefits they've paid into during a lifetime of employment. You'll have the peace of mind knowing that you're getting all the benefits you deserve. So, sit back, relax, and celebrate!

④

Health Savings Account

Associated Bank

Available to employees enrolled in either of the HDHP medical plans.

If you are enrolled in an HSA-qualified plan, you may be eligible to open a tax-free health savings account. The money in your HSA is carried over from year to year so you can budget for current and future expenses. Plus, you own the account so it's yours to keep even if you change jobs or retire.

▶

Is an HSA Right for You?

www.cbmicrosite.com/video/hsa



Visit www.irs.gov and search for IRS Publication 502 to learn more about eligible expenses.

HSA

Pay for eligible medical, dental, vision, and prescription expenses, such as:

- Deductibles
- Other health-related expenses
- Coinsurance

2026 annual contribution limit	Individual	\$4,400
	Family	\$8,750
	Catch-up contribution (Age 55 or older)	\$1,000
2026 annual employer contributions if enrolled in the HSA Choice Care Plan	Individual	\$600
	Family	\$1,900
Rollover		Full Amount

* This amount applies to the IRS annual contribution limit.

All HSA contributions require an open and active account. Contributions cannot be made and are forfeited if no active account exists and cannot be paid later or in a different form.

Your eligibility for an HSA may be misrepresented if you and/or your spouse currently utilize an FSA. Check with the plan administrator or Human Resources to learn more.

HSA Case Study

Justin is a healthy 28-year-old single man who contributes \$1,000 each year to his HSA. His plan's annual deductible is \$1,600 for individual coverage. Here is a look at the first two years of Justin's HSA plan, assuming the use of in-network providers. This example only includes HSA contribution amounts and does not reflect any investment earnings.

Year 1		➔	Year 2	
HSA Balance	\$1,000		HSA Balance	\$1,850
Total Expenses:			Total Expenses:	
Prescription drugs: \$150			Office visit: \$100	
			Prescription drugs: \$200	
			Preventive care services: \$0 (covered by insurance)	
	- \$150			- \$300
HSA Rollover to Year 2	\$850		HSA Rollover to Year 3	\$1,550
Since Justin did not spend all his HSA dollars in year 1, the remaining funds roll over.			Once again Justin did not spend all his HSA dollars, so they roll over to the next year.	

Flexible Spending Account

Associated Bank

Available to all eligible employees.

FSA's can save you money on eligible expenses because you don't have to pay taxes on the amount contributed to the account. However, using an FSA does require careful planning to reap the financial benefits.

Health FSA

Pay for eligible medical, dental, vision, and prescription expenses, such as:

- Deductibles
- Copays
- Coinsurance
- Other health-related expenses

2026 annual contribution limit	\$3,400
Rollover	\$680

Your eligibility for an FSA may be misrepresented if you and/or your spouse currently utilize an HSA. Check with the plan administrator or Human Resources to learn more.

Limited-Purpose FSA

If you contribute to an HSA, you are only eligible to use a Health FSA for dental and vision expenses.


2026 annual contribution limit	\$3,400
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Dependent Care FSA -All employees

Set aside tax-free money to care for children under age 13 or an elderly, dependent parent who is unable to care for themselves. Cover care expenses while you work, such as:

- Preschool
- Summer day camp
- Before and after school programs
- Elder care

2026 annual contribution limit	Married (Filing separately)	\$3,750
	Single/Married (Filing jointly)	\$7,500



Is a Health FSA Right for You?
www.cbmicrosite.com/video/healthfsa



Visit www.irs.gov and search for IRS Publications 502 (Medical and Dental) and 503 (Dependent Care) to learn more about eligible expenses.

Tax-Advantaged Accounts

Associated Bank

	Health Care FSA	Limited-Purpose FSA	HSA	DFSA
Available if you enroll in the Medical Plan	No	Yes	Yes	Yes
Eligible for company contributions	No	No	Yes	No
Ability to change your contribution anytime	Yes*	Yes*	Yes	Yes*
Access only funds that have been deposited	No	No	Yes	No
"Use it or lose it" at year-end	Yes (except \$660 rollover)	Yes (except \$660 rollover)	No	Yes

*If you experience a qualifying life event.

Flexible Spending Accounts

Health FSA

Pay for health care expenses, such as plan deductibles, copay, and coinsurance.

Annual contribution limit	\$3,300
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Your eligibility for an FSA may be misrepresented if you and/or your spouse currently utilize an HSA. Check with the plan administrator or Human Resources to learn more.

Limited-Purpose FSA

Pay for dental and vision expenses.

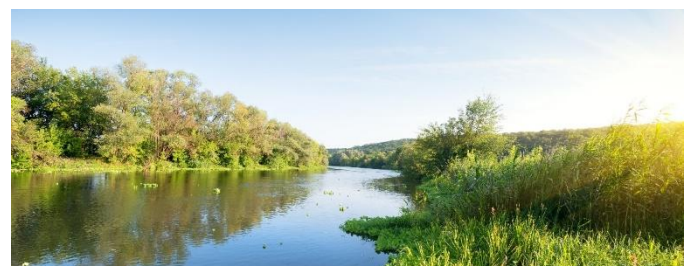
Annual contribution limit	\$3,300
---------------------------	---------

Dependent Care FSA

Pay for dependent care expenses, such as preschool, summer day camp, before and after care for school programs, or child and elder care so you and/or your spouse can work, look for work, or attend school full-time.

Childcare expenses only eligible for children under age 13.

Annual contribution limit	Married (Filing separately)	\$2,500
	Single/Married (Filing jointly)	\$5,000



Visit www.irs.gov and search for IRS Publications 502 (Medical and Dental) and 503 (Dependent Care) to learn more about eligible expenses.

Health Savings Account

HSA

Pay for eligible medical, prescription, dental, and vision expenses for yourself and your family.

Annual contribution limit	Individual	\$4,300
	Family	\$8,550
	Catch-up contribution (Age 55 or older)	\$1,000

Your eligibility for an HSA may be misrepresented if you and/or your spouse currently utilize an FSA. Check with the plan administrator or Human Resources to learn more.

Dental

Ameritas

In addition to protecting your smile, dental insurance helps pay for dental care. Several studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body—including your heart. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.



Locate an Ameritas network provider near you at www.ameritas.com or call 800-487-5553.

Dental	Low Plan		High Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	\$0	\$0	\$50 per member	\$50 per member
Annual Benefit Max (Per person)	\$1,000	\$1,000	\$1,500	\$1,500
Lifetime Orthodontia Max (Per child up to age XX)	Not Covered	Not Covered	\$1,500	\$1,500
Services	In-Network	Out-of-Network	In-Network	Out-of-Network
Preventive Care	100% Covered	100% Covered	100% Covered	100% Covered
Basic	Not Covered	Not Covered	100%	90%
Major	Not Covered	Not Covered	65%	60%
Orthodontia	Not Covered	Not Covered	50%	50%

Please review the full plan documents for details. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

Vision

Ameritas/EyeMed

Driving to work, reading a news article and watching TV are all activities you likely perform every day. Your ability to do all of these activities, though, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems.



Locate a Ameritas network provider near you at www.eyemedvisioncare.com or call 866-289-0614.

Vision	EyeMed Access Network	Out-of-Network
Lens Deductible	\$10	No deductible
Lenses		
Single Visions	Covered in Full	Up to \$20
Bifocal	Covered in Full	Up to \$40
Trifocal	Covered in Full	Up to \$50
Lenticular	20% discount	No benefit
Lens Options (Tints & Coatings) Once every 12 months	\$15 - \$45	No Benefit
Frames Once every 24 months	\$130	Up to \$40
Contact Lenses		
Elective	Up to \$130	Up to \$70
Medically Necessary	Covered in Full	Up to \$200
Contact Lenses		
Standard	Cost up to \$55	No Benefit
Premium	10% off of retail	No Benefit

Frequencies	
Exams	1 per 12 months
Lenses	1 per 12 months
Frames	1 per 24 months
Contact Lenses	1 per 12 months (in lieu of lenses/frames glasses)

Please review the full plan documents for details. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

FSA vs HSA Comparison



PRICE COUNTY
WISCONSIN

To help employees manage out-of-pocket medical costs, we offer health flexible spending arrangements (FSAs) or health savings accounts (HSAs) as part of our benefits package. Learn the key features and benefits of each account below.

	Dependent Care FSA	Health FSA	Limited FSA	HSA
Who can use it?	All employees, regardless of health plan enrollment	Only employees not enrolled on the medical plan	All employees enrolled on the medical plan	All employees enrolled on the medical plan
What can I use it to pay for?	Use to pay for childcare, daycare, and elder care expenses.	Use to pay for medical, prescription, dental, and vision expenses.	Use to pay for dental and vision expenses.	Use to pay for any purpose medical or non-medical expenses.
Who administers it?	Associated Bank	Associated Bank	Associated Bank	Associated Bank
Who owns it?	Employer	Employer	Employer	Employee
Who contributes?	Employee	Employee	Employee	Employer & Employee
How much can I contribute to the account each year? 2026 Annual Contribution Limits:	\$3,750 (married, and filing separately) \$7,500 (married, and filing jointly)	\$3,400	\$3,400	\$4,400 (individual) \$8,750 (family) Catch-up: Contribute an additional \$1,000 if age 55+ by the end of the tax year.
Can unused funds rollover to from year to year?	Grace Period: You may use unused funds 2 ½ months after end of plan year.	Grace Period: You may use unused funds 2 ½ months after end of plan year.	Grace Period: You may use unused funds 2 ½ months after end of plan year.	Yes

Jaw Dropping

betr |



Transformations Guaranteed!

We'll guide you to the best version of you yet — no starvation, fads, or medications needed.



★★★★★ | 4.9 rating from members

Say goodbye to frustration and hello to your new, Betr life!

Betr uses "Food as Medicine", simple lifestyle changes and cutting-edge science to target chronic inflammation - the root cause of poor health.

Forget about band-aid fixes, costly medications counting calories or the latest diet fads. With live 1:1 coaching, community and a 24/7 AI co-pilot, we ensure you get a personalized path to your jaw-dropping transformation.



NEW IN 2026

100% Covered Benefit for Price County Employees and Spouses on a Sponsored Health Plan!

Naturally Improve

- ✓ Energy
- ✓ Digestion
- ✓ Mood
- ✓ Pain
- ✓ Sleep
- ✓ Weight

Scan the QR code to learn more



Or visit:

<https://betrhealth.com/pages/price-county>



Professional therapy, done online, for you & your dependents

BetterHelp makes starting therapy easy and convenient

We have partnered with BetterHelp to support your mental wellbeing by providing you with easy and convenient access to professional therapy online. As a valued member, this benefit is available to **you and your dependents free of charge.**



Get Started:

- ① Click the 'Get Started' link in your BetterHelp invite email. [Clear instructions on how to invite dependents with 'Access Codes' can also be found in that email]
- ② Complete a brief questionnaire to find a therapist that suits your needs and preferences.
- ③ Communicate weekly with your therapist via phone, video or live chat. You can even text your therapist whenever you want.



About BetterHelp:

[FAQ - BetterHelp](#)

Who are the therapists?

BetterHelp therapists are independently licensed clinicians licensed by their state's professional board after successfully completing the necessary education, exams, and training. The 30,000+ therapists on BetterHelp represent a wide variety of expertise, backgrounds, and therapy modalities.

How do I book my sessions?

You can use our scheduling tool to book a live session with your therapist - simply choose the date, time and modality (phone, video or live-chat) for your session. You can even text your therapist whenever you want with our messaging tool.

Discount Program

PerkSpot through our partnership with Cottingham & Butler

This program provides you access to an online marketplace that delivers thousands of discounts for everyday business and personal purchases, leveraging the purchasing power of some of the largest employers in the United States.

Discount Program				
Shop for a Variety of Coupons & Deals from these Categories:	Apparel	Home & Garden		
	Auto Buying	Home Services		
	Automotive	Insurance & Protection Services		
	Beauty & Fragrance	Jewelry & Watches		
	Books, Movies, & Music	Movie Tickets		
	Business Perks	Office & Business		
	Cell Phones	Pets		
	Education	Real Estate & Moving Services		
	Electronics	Sports & Outdoors		
	Financial Wellness	Tickets & Entertainment		
	Flowers & Gifts	Toys, Kids & Babies		
	Food	Travel		
	Health & Wellness			
	Hobbies & Creative Arts			
	Popular Discounted Brands*	Avis	Dell	Home Chef
		Canon	Enterprise	HP
Casper		Holiday	Ray-Ban	
Columbia		Inn		
Benefit Cost	Included in our partnership with Cottingham & Butler			

* All brands and discounts available are subject to change. For a current listing of discounts and brands offered visit the website at <https://cottinghambutler.perkspot.com>.



Unlock discounts for you and your family!

Visit: <https://cottinghambutler.perkspot.com>

Who is PerkSpot?

- Online savings resource for employees
- Headquartered in Chicago, IL – Founded in 2006
- 750+ clients nationwide, 15 million members
- 30,000+ discount offers

Website Features

- Recommended for You: chosen based on your top interests
- Featured Offers: hand-selected to help you stretch your dollars
- Today's Perk Alters: today's best limited-time sales
- Popular Savings: trending offers
- Categories: shop by category
- Local Discounts: shop by location

Discount Program

Perkspot

Through our partnership with Cottingham & Butler, we have access to the PerkSpot Employee Discount Program at no cost to you!

This program provides you access to an online marketplace that delivers thousands of discounts for everyday business and personal purchases, leveraging the purchasing power of some of the largest employers in the United States.

Who is PerkSpot?

- Online savings resource for employees
- Headquartered in Chicago, IL
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Website Features

- **Recommended for You:** chosen based on your top interests
- **Featured Offers:** hand-selected to help you stretch your dollars
- **Today's Perk Alters:** today's best limited-time sales
- **Popular Savings:** trending offers
- **Categories:** shop by category
- **Local Discounts:** shop by location

Create Your Account

1. Visit <https://cottinghambutler.perkspot.com/>
2. Click "**Create an Account**"
3. Enter your Name, Email, Gender, Zip Code and create a Password
4. Sign up for email updates
 - a. **Weekly Perks:** Stay up to date on the best discounts and exclusive offers available to you
 - b. **theLOOP:** PerkSpot's weekly resource for how to excel in the 21st century workplace. Providing insights into workplace trends, lifestyle practices, and strategies for success
5. Click "**Register**"
6. Browse discount offers from over 25 categories

Shop for a Variety of Coupons & Deals from these Categories:

- Apparel
- Auto Buying
- Automotive
- Beauty & Fragrance
- Books, Movies, & Music
- Business Perks
- Cell Phones
- Education
- Electronics
- Financial Wellness
- Flowers & Gifts
- Food
- Health & Wellness
- Hobbies & Creative Arts
- Home & Garden
- Home Services
- Insurance & Protection Services
- Jewelry & Watches
- Movie Tickets
- Office & Business
- Pets
- Real Estate & Moving Services
- Sports & Outdoors
- Tickets & Entertainment
- Toys, Kids & Babies
- Travel

Popular Discounted Brands*:

- Avis
- Canon
- Casper
- Columbia
- Dell
- Enterprise
- Holiday Inn
- Home Chef
- HP
- Ray-Ban

**All brands and discounts available are subject to change. For a current listing of discounts and brands offered visit the website at <https://cottinghambutler.perkspot.com/>*

Benefit Terms

The world of health insurance has many terms that can be confusing. Understanding your costs and benefits—and estimating the price of a visit to the doctor—becomes much easier once you are able to make sense of the terminology.

Definitions

- **Annual limit**—Cap on the benefits your insurance company will pay in a given year while you are enrolled in a particular health insurance plan.
- **Claim**—A bill for medical services rendered.
- **Cost-sharing**—Health care provider charges for which a patient is responsible under the terms of a health plan. This includes deductibles, coinsurance and copayments.
- **Coinsurance**—Your share of the costs of a covered health care service calculated as a percentage of the allowed amount for the service.
- **Copayment (copay)**—A fixed amount you pay for a covered health care service, usually when you receive the service.
- **Deductible**—The amount you owe for health care services each year before the insurance company begins to pay. Example: John has a health plan with a \$1,000 annual deductible. John falls off his roof and has to have three knee surgeries, the first of which is \$800. Because John hasn't paid anything toward his deductible yet this year, and because the \$800 surgery doesn't meet the deductible, John is responsible for 100 percent of his first surgery.
- **Dependent Coverage**—Coverage extended to the spouse and children of the primary insured member. Age restrictions on the coverage may apply.
- **Explanation of Benefits (EOB)**—A statement sent from the health insurance company to a member listing services that were billed by a provider, how those charges were processed and the total amount of patient responsibility for the claim.
- **Group Health Plan**—A health insurance plan that provides benefits for employees of a business.
- **In-network Provider**—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.
- **Inpatient Care**—Care rendered in a hospital when the duration of the hospital stay is at least 24 hours.
- **Insurer (carrier)**—The insurance company providing coverage.
- **Insured**—The person with the health insurance coverage. For group health insurance, your employer will typically be the policyholder and you will be the insured.
- **Open Enrollment Period**—Time period during which eligible persons may opt to sign up for coverage under a group health plan.
- **Out-of-network Provider**—A provider who is not contracted with your health insurance company.
- **Out-of-pocket Maximum (OOPM)**—The maximum amount you should have to pay for your health care during one year, excluding the monthly premium. After you reach the annual OOPM, your health insurance or plan begins to pay 100 percent of the allowed amount for covered health care services or items for the rest of the year.
- **Outpatient Care**—Care rendered at a medical facility that does not require overnight hospital admittance or a hospital stay lasting 24 hours or more.
- **Policyholder**—The individual or entity that has entered into a contractual relationship with the insurance carrier.
- **Premium**—Amount of money charged by an insurance company for coverage.
- **Preventive Care**—Medical checkups and tests, immunizations and counseling services used to prevent chronic illnesses from occurring.
- **Provider**—A clinic, hospital, doctor, laboratory, health care practitioner or pharmacy.
- **Qualifying Life Event**—A life event designated by the IRS that allows you to amend your current plan or enroll in new health insurance. Common life events include marriage, divorce, and having or adopting a child.
- **Qualified Medical Expense**—Expenses defined by the IRS as the costs attached to the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body.
- **Summary of Benefits and Coverage (SBC)**—An easy-to-read outline that lets you compare costs and coverage between health plans.

Acronyms

- **ACA**—Affordable Care Act
- **CDHC**—Consumer driven or consumer directed health care
- **CDHP**—Consumer driven health plan
- **CHIP**—The Children's Health Insurance Program. A program that provides health insurance to low-income children, and in some states, pregnant women who do not qualify for Medicaid but cannot afford to purchase private health insurance.
- **CPT Code**—Current procedural terminology code. A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities, such as physicians, health insurance companies and accreditation organizations.
- **FPL**—Federal poverty level. A measure of income level issued annually by the Department of Health and Human Services (HHS) and used to determine eligibility for certain programs and benefits.
- **FSA**—Flexible spending account. An employer-sponsored savings account for health care expenses.
- **HDHP**—High deductible health plan
- **HMO**—Health maintenance organization
- **HRA**—Health reimbursement arrangement. An employer-funded arrangement that reimburses employees for certain medical expenses.
- **HSA**—Health savings account. A tax-advantaged savings account that accompanies HDHPs.
- **OOP**—Out-of-pocket limit. The maximum amount you have to pay for covered services in a plan year.
- **PCE**—Pre-existing condition exclusion. A plan provision imposing an exclusion of benefits due to a pre-existing condition.
- **PPO**—Preferred provider organization. A type of health plan that contracts with medical providers (doctors and hospitals) to create a network of participating providers. You pay less when using providers in the plan's network, but can use providers outside the network for an additional cost.
- **QHP**—Qualified health plan. A certified health plan that provides an essential health benefits package. Offered by a licensed health insurer.

Price County Group Health Plan: Important Disclosures & Notices

Michelle's Law Notice

If the Plan provides for dependent coverage that is based on a dependent's full-time student status, then this Michelle's Law Notice applies. If there is a medically necessary leave of absence from a post-secondary educational institution or other change in enrollment that: (1) begins while a dependent child is suffering from a serious illness or injury; (2) is certified by a physician as being medically necessary; and (3) causes the dependent child to lose student status for purposes of coverage under the plan, that child may maintain dependent eligibility for up to one year. If the treating physician does not provide written documentation when requested by the Plan Administrator that the serious illness or injury has continued, making the leave of absence medically necessary, the plan will no longer provide continued coverage.



Benefits during a Leave of Absence

Your health benefits may be protected and maintained during a leave of absence, such as a leave qualifying under the Family Medical Leave Act. Other leaves of absence may, however, render you ineligible to participate in the health plan. If coverage is lost due to a leave of absence, you may be eligible to continue coverage under COBRA. Similarly, if you become ineligible for health benefits due to a leave of absence for military reasons, you may be eligible to continue that coverage under USERRA. Please contact your Human Resources Department or your manager for more information regarding what benefits are protected and maintained during a leave of absence and for more information about FMLA, COBRA and USERRA. ❖

Premium Assistance under Medicaid and The Children's Health Insurance Program (CHIP)

If an Employee or an Employee's children are eligible for Medicaid or CHIP and are eligible for health coverage from an employer, the state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If the Employee or his/her children are not eligible for Medicaid or CHIP, they will not be eligible for these premium assistance programs but they may be able to buy individual insurance coverage through the Health Insurance

Marketplace. For more information, visit www.healthcare.gov.

If an Employee or his/her dependents are already enrolled in Medicaid or CHIP and they live in a State listed below, they may contact the State Medicaid or CHIP office to find out if premium assistance is available.

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

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

Employees living in one of the following States may be eligible for assistance paying employer health plan premiums. The following list of States is current as of July 31, 2025. V 0.6.0. The most recent CHIP notice can be found at <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra>. Contact the respective State for more information on eligibility –

ALABAMA – Medicaid
Website: <http://myalhcpp.com/>
Phone: 1-855-692-5447

ALASKA – Medicaid
AK Health Insurance Premium Payment Program
Website: <http://myakhcpp.com/>
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
<https://dhss.alaska.gov/dpa/Pages/default.aspx>

ARKANSAS – Medicaid
Website: <http://myarhcpp.com/>
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
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+)
Health First Colorado Website: <https://www.healthfirstcolorado.com/>
Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711
CHP+ Website: <https://hcpf.colorado.gov/child-health-plan-plus>
CHP+ Customer Service: 1-800-359-1991/State Relay 771
Health Insurance Buy-In Program (HIBI) Website: <https://www.mycohibi.com/>
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: <https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html>
Phone: 1-877-357-3268

GEORGIA – 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

INDIANA – Medicaid
Health Insurance Premium Payment Program All other Medicaid
Website: <https://www.in.gov/medicaid/>
<http://www.in.gov/fssa/dfr/>
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: [iowa Medicaid | Health & Human Services](http://iowa.gov/health-human-services)
Medicaid Phone: 1-800-338-8366
Hawki Website: [Hawki - Healthy and Well Kids in Iowa | Health & Human Services](http://iowa.gov/health-human-services)
Hawki Phone: 1-800-257-8563
HIPP Website: [Health Insurance Premium Payment \(HIPP\) | Health & Human Services](http://iowa.gov/health-human-services)

(iowa.gov)

HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: <https://www.kancare.ks.gov/>

Phone: 1-800-792-4884

HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: <https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>

Phone: 1-855-459-6328

Email: KIHIPP.PROGRAM@ky.gov

KCHIP Website: <https://kynect.ky.gov>

Phone: 1-877-524-4718

Kentucky Medicaid Website:

<https://chfs.ky.gov/agencies/dms>

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or

www.ldh.la.gov/lahipp

Phone: 1-888-342-6207 (Medicaid hotline) or

1-855-618-5488 (LaHIPP)

MAINE – Medicaid

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

MASSACHUSETTS – Medicaid and CHIP

Website:

<https://www.mass.gov/masshealth/pa>

Phone: 1-800-862-4840

TTY: 711

Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website:

<https://mn.gov/dhs/health-care-coverage/>

Phone: 1-800-657-3672

MISSOURI – Medicaid

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>

Phone: 573-751-2005

MONTANA – Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>

Phone: 1-800-694-3084

Email: HSHHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>

Phone: 1-855-632-7633

Lincoln: 402-473-7000

Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: <http://dhcfp.nv.gov>

Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: <https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>

Phone: 603-271-5218

Toll free number for the HIPP program:

1-800-852-3345, ext. 15218

Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>

Phone: 1-800-356-1561

CHIP Premium Assistance Phone: 609-631-2392

CHIP Website:

<http://www.njfamilycare.org/index.html>

CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/

Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: <https://medicaid.ncdhhs.gov/>

Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: <https://www.hhs.nd.gov/healthcare>

Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org>

Phone: 1-888-365-3742

OREGON – Medicaid

Website:

<http://healthcare.oregon.gov/Pages/index.aspx>

Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: <https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html>

Phone: 1-800-692-7462

CHIP Website: [Children's Health Insurance Program \(CHIP\) \(pa.gov\)](http://www.childrenshealthinsuranceprogram.pa.gov)

CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: <http://www.eohhs.ri.gov/>

Phone: 1-855-697-4347 or

401-462-0311 (Direct Rlte Share Line)

SOUTH CAROLINA – Medicaid

Website: <https://www.scdhhs.gov>

Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: <http://dss.sd.gov>

Phone: 1-888-828-0059

TEXAS – Medicaid

Website: <https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program>

Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP) Website:

<https://medicaid.utah.gov/upp/>

Email: upp@utah.gov

Phone: 1-888-222-2542

Adult Expansion Website:

<https://medicaid.utah.gov/expansion/>

Utah Medicaid Buyout Program Website:

<https://medicaid.utah.gov/buyout-program/>

CHIP Website: <https://chip.utah.gov/>

VERMONT – Medicaid

Website: <https://dvha.vermont.gov/members/medicaid/hipp-program>

Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

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

Website: <https://www.hca.wa.gov/>

Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

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

Website: <https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>

Phone: 1-800-362-3002

WYOMING – Medicaid

Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>

Phone: 1-800-251-1269

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

U.S. Department of Labor
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 ❖

Patient Protection Notice

If the Price County Group Health Plan generally requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care

provider automatically, you will be able to designate a new provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Human Resources. ❖

Women's Health and Cancer Rights Act of 1998

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

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prosthesis.
- 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. ❖

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers offering group health insurance coverage 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 normal 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 or 96 hours, as applicable. Additionally, no group health plan or issuer may require that a provider obtain authorization from the Plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). ❖

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law took effect in 2014, a new way to buy health insurance became available: the Health Insurance Marketplace. To assist Employees as they evaluate options for themselves and their family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by their employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help individuals

and families find health insurance that meets their needs and fits their budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. Employees may also be eligible for a new kind of tax credit that lowers their monthly premium right away. The open enrollment period for health insurance coverage through the Marketplace began on Nov. 1st, and ended on Dec. 15. Individuals must have enrolled or changed plans prior to Dec. 15, for coverage starting as early as Jan. 1st. After Dec. 15th, individuals can get coverage through the Marketplace only if they qualify for a special enrollment period.

Can individuals Save Money on Health Insurance Premiums in the Marketplace?

Individuals may qualify to save money and lower monthly premiums, but only if their employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on premiums depends on household income.

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

Yes. If the Employee has an offer of health coverage from his/her employer that meets certain standards, they will not be eligible for a tax credit through the Marketplace and may wish to enroll in their employer's health plan. However, an individual may be eligible for a tax credit that lowers their monthly premium, or a reduction in certain cost-sharing if their employer does not offer coverage at all or does not offer coverage that meets certain standards. If the cost of a plan from an employer that would cover the Employee (and not any other members of their family) is more than 9.96% of household income for the plan year beginning in 2026, or if the coverage the employer provides does not meet the "minimum value" standard set by the Affordable Care Act, the Employee may be eligible for a tax credit.*

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

How Can Individuals Get More Information?

For more information about coverage offered by the Employer, please check the summary plan description or contact Human Resources.

The Marketplace can help when evaluating coverage options, including 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 the area.

* 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% of such costs. ❖

Special Enrollment Rights

If an employee declines enrollment for him/herself or for their dependents (including their spouse) because of other health insurance coverage, they may be able to enroll him/herself or their dependents in this Plan in the future, provided they request enrollment within 30 days after their other coverage ends. Coverage will begin under this Plan no later than the first day of the first month beginning after the date the plan receives a timely request for enrollment.

If an employee acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption, they may be able to enroll him/herself and their dependents provided that they request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If an employee adds coverage under these circumstances, they may add coverage mid-year. For a new spouse or dependent acquired by marriage, coverage is effective no later than the first day of the first month beginning after the date the plan receives a timely request for the enrollment. When a new dependent is acquired through birth, adoption, or placement for adoption, coverage will become effective retroactive to the date of the birth, adoption, or placement for adoption. The plan does not permit mid-year additions of coverage except for newly eligible persons and special enrollees.

Individuals gaining or losing Medicaid or State Child Health Insurance Coverage (SCHIP)

If an employee or their dependent was:

1. covered under Medicaid or a state child health insurance program and that coverage terminated due to loss of eligibility, or
2. becomes eligible for premium assistance under Medicaid or state child health insurance program, a special enrollment period under this Plan will apply.

The employee must request coverage under this Plan within 60 days after the termination of such Medicaid or SCHIP, or within 60 days of becoming eligible for the premium assistance from Medicaid or the SCHIP. Coverage under the plan will become effective on the date of termination of eligibility for Medicaid/State child health insurance program, or the date of eligibility for premium assistance under Medicaid or SCHIP. ❖

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INDIVIDUAL MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW TO GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HIPAA Notice of Privacy Practices

The Price County Group Medical Plan (the “Plan”), which may include other health and welfare benefit offerings, are required by law (under the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 HIPAA’s privacy rule) to take reasonable steps to ensure the privacy of personally identifiable health information. This Notice is being provided to inform employees (and any of their dependents) of the policies and procedures Price County has implemented and their rights under them, as well as under HIPAA. These policies are meant to prevent any unnecessary disclosure of individual health information.

Use and Disclosure of individually identifiable Health Information by the Plan that Does Not Require the Individual’s Authorization: The plan may use or disclose health information (that is protected health information (PHI)), as defined by HIPAA’s privacy rule) for:

1. Payment and Health Care

Operations: In order to make coverage determinations and payment (including, but not limited to, billing, claims management, subrogation, and plan reimbursement). For example, the Plan may provide information regarding an individual’s coverage or health care treatment to other health plans to coordinate payment of benefits. Health information may also be used or disclosed to carry out Plan operations, such as the administration of the Plan and to provide coverage and services to the Plan’s participants.

For example, the Plan may use health information to project future benefit costs, to determine premiums, conduct or arrange for case management or medical review, for internal grievances, for auditing purposes, business planning and management activities such as planning related analysis, or to contract for stop-loss coverage. Pursuant to the Genetic Information Non-Discrimination Act (GINA), the Plan does not use or disclose genetic information for underwriting purposes.

2. Disclosure to the Plan Sponsor:

As required, in order to administer benefits under the Plan. The Plan may also provide health information to the plan sponsor to allow the plan sponsor to solicit premium bids from health insurers, to modify the Plan, or to amend the Plan.

3. Requirements of Law:

When required to do so by any federal, state or local law.

4. Health Oversight Activities:

To a health oversight agency for activities such as audits, investigations, inspections, licensure, and other proceedings related to the oversight of the health plan.

5. Threats to Health or Safety:

As required by law, to public health authorities if the Plan, in good faith, believes the disclosure is necessary to prevent or lessen a serious or imminent threat to an individual’s health or safety or to the health and safety of the public.

6. Judicial and Administrative

Proceedings: In the course of any administrative or judicial proceeding in response to an order from a court or administrative tribunal, in response to a subpoena, discovery request or other similar process. The Plan will make a good faith attempt to provide written notice to the individual to allow them to raise an objection.

7. Law Enforcement Purposes:

To a law enforcement official for certain enforcement purposes, including, but not limited to, the purpose of identifying or locating a suspect, fugitive, material witness or missing person.

8. Coroners, Medical Examiners, or

Funeral Directors: For the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law.

9. Organ or Tissue Donation:

If the person is an organ or tissue donor, for purposes related to that donation.

10. Specified Government Functions:

For military, national security and intelligence activities, protective services, and correctional institutions and inmates.

11. Workers’ Compensation:

As necessary to comply with workers’ compensation or other similar programs.

12. Distribution of Health-Related

Benefits and Services: To provide information to the individual on health-related benefits and services that may be of interest to them.

Notice in Case of Breach

Price County is required to maintain the privacy of PHI; to provide individuals with this notice of the Plan’s legal duties and privacy practices with respect to PHI; and to notify individuals of any breach of their PHI.

Use and Disclosure of Individual Health Information by the Plan that Does Require Individual

Authorization: Other than as listed above, the Plan will not use or disclose without your written authorization. You may revoke your authorization in writing at any time, and the Plan will no longer be able to use or disclose the health information. However, the Plan will not be able to take back any disclosures already made in

accordance with the Authorization prior to its revocation. The following uses and disclosures will be made only with authorization from the individual: (i) most uses and disclosures of psychotherapy notes (if recorded by a covered entity); (ii) uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this notice.

Individual Rights with Respect to Personal Health Information: Each individual has the following rights under the Plan's policies and procedures, and as required by HIPAA's privacy rule:

Right to Request Restrictions on Uses and Disclosures: An individual may request the Plan to restrict uses and disclosures of their health information. The Plan will accommodate reasonable requests; however, it is not required to agree to the request, unless it is for services paid completely by the individual out of their own pocket. A wish to request a restriction must be sent in writing to HIPAA Privacy Officer, at Price County, 126 Cherry St., Phillips, WI 54555, 715-339-3701.

Right to Inspect and Copy Individual Health Information: An individual may inspect and obtain a copy of their individual health information maintained by the Plan. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. A written request must be provided to HIPAA Privacy Officer at Price County, 126 Cherry St., Phillips, WI 54555, 715-339-3701. If the individual requests a copy of their health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if

applicable, associated with their request.

Right to Amend Your Health

Information: You may request the Plan to amend your health information if you feel that it is incorrect or incomplete. The Plan has 60 days after the request is made to make the amendment. A single 30-day extension is allowed if the Plan is unable to comply with this deadline. A written request must be provided to HIPAA Privacy Officer, at Price County, 126 Cherry St., Phillips, WI 54555, 715-339-3701. The request may be denied in whole or part and if so, the Plan will provide a written explanation of the denial.

Right to an Accounting of

Disclosures: An individual may request a list of disclosures made by the Plan of their health information during the six years prior to their request (or for a specified shorter period of time). However, the list will not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) disclosures made prior to April 14, 2004; (3) to individuals about their own health information; and (4) disclosures for which the individual provided a valid authorization.

A request for an accounting form must be used to make the request and can be obtained by contacting the HIPAA Privacy Officer at Price County, 126 Cherry St., Phillips, WI 54555, 715-339-3701. The accounting will be provided within 60 days from the submission of the request form. An additional 30 days is allowed if this deadline cannot be met.

Right to Receive Confidential

Communications: An individual may request that the Plan communicate with them about their health information in a certain way or at a certain location if they feel the disclosure could endanger them. The individual must provide the request in writing to the HIPAA Privacy Officer at Price County, 126 Cherry St., Phillips,

WI 54555, 715-339-3701. The Plan will attempt to honor all reasonable requests.

Right to a Paper Copy of this Notice:

Individuals may request a paper copy of this Notice at any time, even if they have agreed to receive this Notice electronically. They must contact their HIPAA Privacy Officer at Price County, 126 Cherry St., Phillips, WI 54555, 715-339-3701 to make this request.

The Plan's Duties: The Plan is required by law to maintain the privacy of individual health information as related in this Notice and to provide this Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains.

Complaints and Contact Person:

If an individual wishes to exercise their rights under this Notice, communicate with the Plan about its privacy policies and procedures, or file a complaint with the Plan, they must contact the HIPAA Contact Person, at Price County, 126 Cherry St., Phillips, WI 54555, 715-339-3701. They may also file a complaint with the Secretary of Health and Human Services if they believe their privacy rights have been violated. ❖

Important Notice from Price County Group Health Plan about Your Prescription Drug Coverage and Medicare (Creditable Coverage)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription

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

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current Price County coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Price County coverage,

be aware that you and your dependents will be able to get this coverage back.

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

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

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

For More Information about this Notice or Your Current Prescription Drug Coverage

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Price County 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: November 5, 2025

Name of Entity/Sender: Price County

Contact--Position/Office: Human Resources

Address: 126 Cherry St., Phillips, WI 54555

Phone Number: 715-339-3701 ❖

