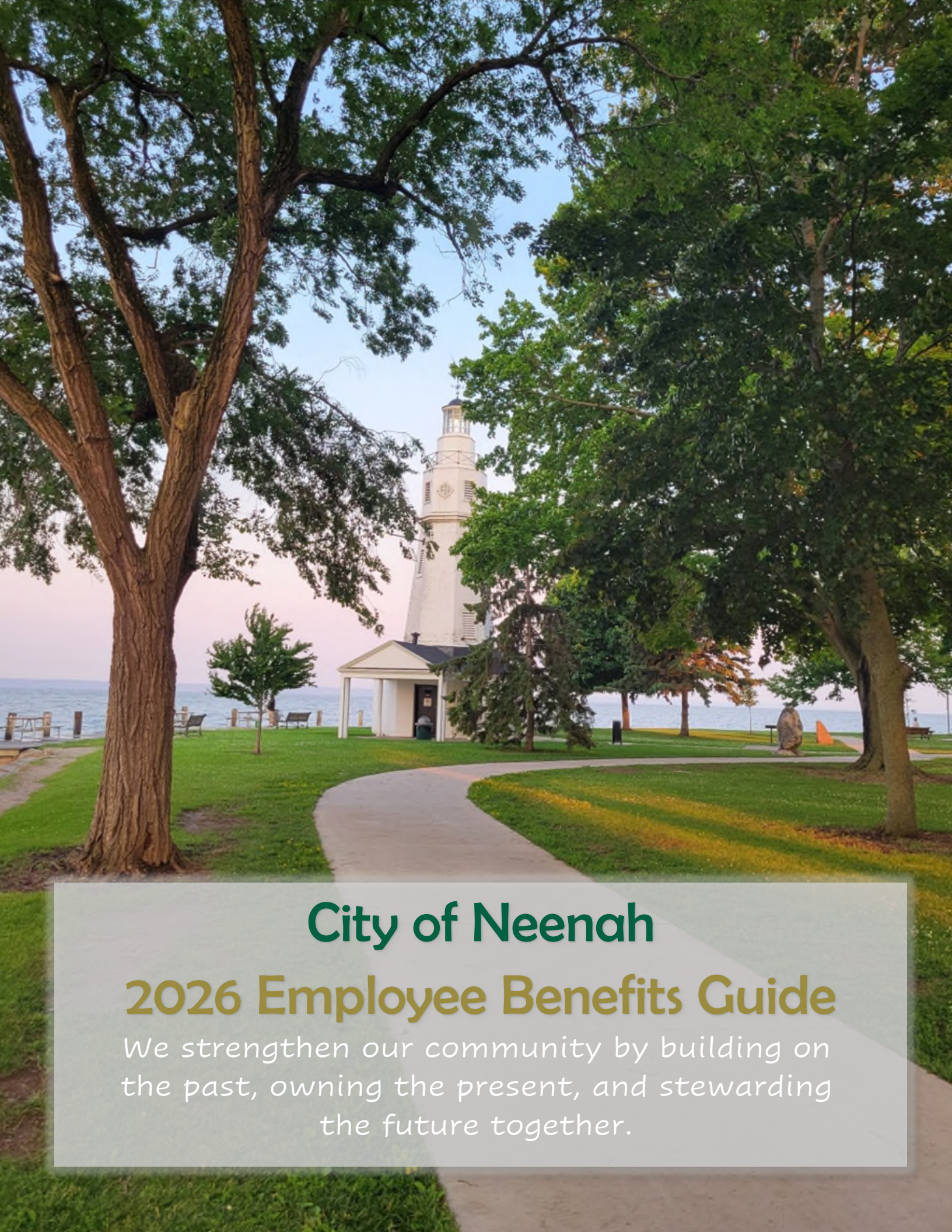


City of Neenah

2026 Employee Benefits Guide

We strengthen our community by building on the past, owning the present, and stewarding the future together.

OUR MISSION

We strengthen our community by building on the past, owning the present, and stewarding the future together.

OUR VALUES

Pursue Growth
Individual development positively influences the community.

Cultivate Collaborative Relationships
Succeed by fostering mutual respect as we grow and work together.

Encourage Innovation
Anticipate change. Embrace creativity and inspire ideas.

Engage with Our Community
Acknowledge people. Hear people. Include people.

Table of Contents

This guide will help you get to know your benefits and your choices for the 2026 plan year. Be sure to learn about your options so you can make informed choices for yourself and your eligible dependents.

A Message from Human Resources

City Employees,

First and foremost, congratulations on a successful plan year! Thanks to everyone's responsible use of our health plan, our overall renewal came in strong. We were able to maintain our current plan design with only a small increase tied to the cost of our stop-loss insurance (that's the secondary coverage that protects the plan from large, unexpected claims).

Because our claims stayed on track, we're happy to share some great news! We've been able to lower the overall employee contribution rates *and* the maximum out-of-pocket costs for health insurance, while also creating a new four-tier rate structure. This is especially good news for employees who don't have both a spouse and children but still need coverage beyond employee-only.

Another exciting addition this year is the Family Savings Plan. This new benefit is designed to support employees who currently use the City's health plan but also have the option to be covered elsewhere, helping them transition more easily to alternate coverage. (Don't worry, this does not impact those already participating in the opt-out program.) However, there *is* a way for employees currently in the opt-out program to qualify for the Family Savings Plan if they choose, and you'll find those details in the corresponding section of this benefit guide.

And finally, we heard your feedback about wanting an alternative to our current dental plan. We're pleased to introduce an HMO Dental Plan that offers enhanced benefits within a slightly more focused provider network. This is an *additional* option. Our current dental plan will remain available for those who prefer to keep their existing coverage, although there will be a slight rate change.

Thank you for helping make this such a positive year! Your continued engagement and smart use of benefits truly make a difference, and we're looking forward to another great year ahead.

Kind Regards,

Amy J. Fairchild, SHRM CP
Director of Human Resources and Safety

Benefits Menu | Carrier Contacts

Coverage	Carrier	Contact
Medical	UMR	800.207.3172 www.umr.com
Family Savings Plan	Network Health Plan	877.872.4232 FSP@catilizehealth.com
Employee Clinic	ThedaCare	920.886.6155
Delta Dental	Delta Dental	800.236.3712 deltadentalwi.com
Vision	Delta Vision	844.848.7090 deltadentalwi.com
CarePlus Dental	CarePlus Dental	800.318.7007 Careplusdentalplans.com
Employee Assistance Program	Ascension	800.540.3758 ascensionwieap.org
Health Reimbursement Account	Diversified Benefits Services	800.234.1229 dbsbenefits.com
Flexible Spending Account	Diversified Benefits Services	800.234.1229 dbsbenefits.com
COBRA Administration	Diversified Benefits Services	800.234.1229 dbsbenefits.com
Life Insurance	Securian Financial	866.295.8690 etf.wi.gov/benefits/benefits-provided-etf/life-insurance
Voluntary Accident, Critical Illness, Hospital Indemnity	The Standard	1.888.937.4783 www.standard.com
Pet Insurance	Spot Pet	888.343.2340 (priority code: EB_NEENAHWI)
Pension	WRS/ETF Department of Employee Trust Funds	877.533.5020 etf.wi.gov
Deferred Compensation and Roth IRA	Mission Square Independent Investment Advisors – M3 Financial	Kevin Linsmeier Klinsmeier@missionsq.org 202.759.7147 Nicholas Natzke Nicholas.natzke@m3ins.com 920.455.7290

Human Resources Contacts

Team Member	Contact
Human Resources & Safety Assistant	920.886.6102
Human Resources Recruitment and Retention Coordinator	920.886.6112
Director of Human Resources & Safety	920.886.6103

WELCOME

Enrollment Guide

Your Benefit Period

JANUARY 1, 2026 – DECEMBER 31, 2026

ENROLLMENT INSTRUCTIONS

1. Review the information in this guide and benefit plan summaries.

2. If making changes or enrolling in the FSA, complete your enrollment in Bentek.
   a. See flyer on next page for instructions

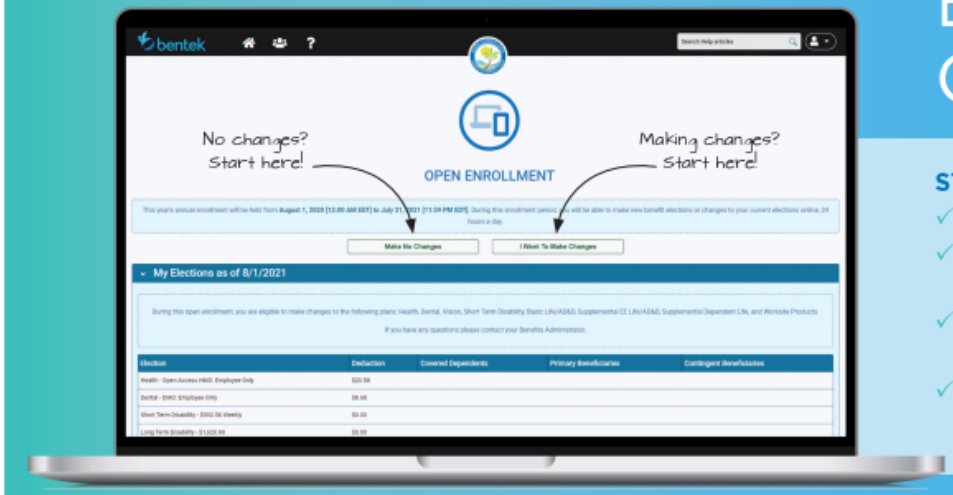
HELPFUL TIPS TO CONSIDER BEFORE YOU ENROLL:

1. This year's open enrollment is active, and all employees are required to complete their enrollment elections through Bentek. Failure to do so may result in the loss of current coverage.
   a. NOTE: If you wish to enroll in the **FLEXIBLE SPENDING ACCOUNT (FSA),** you **MUST** enter a new election amount for 2026 in Bentek.

IMPORTANT:

For mid-year qualifying life events, you must notify HR to change elections within 30 days of the qualifying event.

Bentek Enrollment Quick Guide



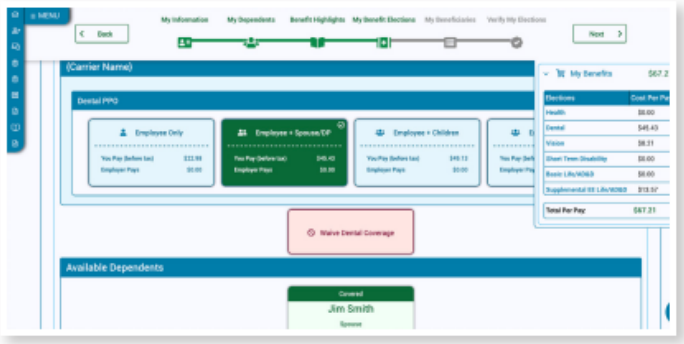
START YOUR ENROLLMENT SESSION!

- ✓ Log on to **app.mybentek.com/neenahwi**
- ✓ View your current elections, deduction amounts, covered dependents, and beneficiaries.
- ✓ Click "Make No Changes" to submit your session as shown under My Elections.
- ✓ Click "I Want To Make Changes" to start your enrollment session.

To access Bentek using a mobile device, scan code.

ENROLLMENT IN SIX EASY STEPS

1. **My Information** – Verify your demographic information is correct.
2. **My Dependents** – Verify your current dependent information.
   - › Add a new dependent by clicking "+ Dependent"
3. **Benefits Highlights** – Enrollment news, coverage options, plan documents and carrier information.
4. **My Benefit Elections** – Add/remove/change plans, add/remove dependents, and track per-pay deductions in your Benefits Cart.
   - › Selected plans and covered dependents will show in green.
5. **My Beneficiaries** – Add, remove, or change beneficiary information.
   - › Add a new beneficiary by clicking "+ Person" or "+ Trust"
6. **Verify My Elections** – Review enrollment elections and submit your session.
   - › Life insurance requiring carrier approval will show as pending.



ELIGIBILITY

EMPLOYEE ELIGIBILITY

Coverage is effective the first of the month following date of hire for benefit eligible employees. Benefit eligible is defined as:

- Full-Time employees working 37.5 hours or more
- Part-Time employees working between 30 and 37 hours on average (a premium adjustment may apply)

DEPENDENT ELIGIBILITY

You may also enroll eligible dependents for benefits coverage. A **'dependent'** is defined as the **legal spouse** and/or **'dependent child(ren)'** of the plan participant or spouse.

The term "child" refers to any of the following:

- A natural biological child
- A stepchild
- A legally adopted child or child legally placed for adoption
- Legal Guardianship as ordered by a court
- Qualified Medical Child Support Order
- Unmarried grandchild until grandchild is no longer eligible or until parent is 18
- Disabled dependents may be eligible if requirements set by the plan are met.

The chart below explains who is eligible for coverage under each type of benefit plan:

Line of Coverage	When Coverage Ends
Employees are eligible for Medical, Employee Clinic, Dental, Vision, EAP, HRA, FSA, Life Insurance, Critical Illness, Accident, Hospital Indemnity, Pension, Deferred Compensation and Roth IRA	*Coverage ends the last day of the calendar month of your event date.*
Spouses are eligible for Medical, Employee Clinic, Dental, Vision, EAP, HRA, FSA, Critical Illness, Accident, Hospital Indemnity	*Coverage ends the last day of the calendar month of your event date.*
Dependents are eligible for Medical, Employee Clinic, Dental, Vision, EAP, HRA, FSA, Critical Illness, Accident, Hospital Indemnity	*Coverage ends the last day of the calendar month of your event date.*

QUALIFYING LIFE EVENTS

If you have a Qualifying Life Event and want to request a mid-year change, you must notify Human Resources and complete your election changes within 30 days following the event (60 days for birth, adoption, or placement for adoption). Be prepared to provide documentation to support the Qualifying Life Event.

Common life events include: Marriage, Divorce, New Dependent, Loss/Gain of available coverage by you or any of your dependents.

***A full list of qualifying events can be found in the 'Required Notices' section of this benefits guide.**

IMPORTANT

You cannot make changes to your insurance elections during the year unless you experience a qualified life event, which must be reported to Human Resources within 30 days of the event.

If you separate from employment, COBRA continuation of coverage may be available as applicable by law. COBRA continuation details can be found in the notices section of this benefit guide.

2026 Rate Overview

The chart below outlines core benefits and rates. For full plan details, see the associated section of this guide.

Health	Monthly Premium	Employer Monthly	Employee Monthly	Employee Per Pay
Employee Only	$ 819.26	$ 737.34	$ 81.92	$ 40.96
Employee Plus Child(ren)	$ 1,474.68	$ 1,327.20	$ 147.48	$ 73.74
Employee Plus Spouse	$ 1,884.32	$ 1,695.88	$ 188.44	$ 94.22
Employee Plus Family	$ 3,277.06	$ 2,949.34	$ 327.72	$ 163.86

Dental	Monthly Premium	Employer Monthly	Employee Monthly	Employee Per Pay
Delta Employee Only	$ 52.68	$ 44.78	$ 7.90	$ 3.95
Delta Employee + Child(ren)	$ 116.56	$ 99.08	$ 17.48	$ 8.74
Delta Employee + Spouse	$ 105.36	$ 89.56	$ 15.80	$ 7.90
Delta Family	$ 159.56	$ 135.64	$ 23.92	$ 11.96
CarePlus Employee Only	$ 44.78	$ 44.78	$ -	$ -
CarePlus Employee + Child(ren)	$ 99.08	$ 84.22	$ 14.86	$ 7.43
CarePlus Employee + Spouse	$ 89.56	$ 76.14	$ 13.42	$ 6.71
CarePlus Family	$ 135.63	$ 115.29	$ 20.34	$ 10.17

Vision	Monthly Premium	Employer Monthly	Employee Monthly	Employee Per Pay
Employee Only	$ 6.56	$ -	$ 6.56	$ 3.28
Employee Plus Child(ren)	$ 13.12	$ -	$ 13.12	$ 6.56
Employee Plus Spouse	$ 11.80	$ -	$ 11.80	$ 5.90
Employee Plus Family	$ 17.30	$ -	$ 17.30	$ 8.65

The benefits reflected in this table are based on 24 pay cycles per year

Rates are effective 1/1/2026 through 12/31/2026

Neenah WISCONSIN

Medical Plan

You get the most from your benefits when you take the time to learn about your options and make decisions that are best for you and your family. Your medical plan is administered by UMR, with access to the UnitedHealthcare Choice Plus Network.

Your plan year runs from January 1, 2026 - December 31, 2026 and your deductible will reset on January 1.

You generally pay less when you receive care from doctors, hospitals and other health care facilities that participate in the UnitedHealthcare Choice Plus network. Find a participating health care provider in your area by going to: UMR.com > Find a Provider > and searching for the UnitedHealthcare Choice Plus network.

Refer to the Summary Plan Description (SPD) or Summary of Benefits and Coverage (SBC) for detailed medical plan coverage information.

It is crucial that you confirm whether your pharmacy, physician, hospital, prescription drugs, therapists, chiropractors, eye doctors, etc. are covered by the plan before you receive care.

Retirees (and/or their spouses) are allowed to stay on the City's health insurance until they are Medicare eligible. Retirees will be charged the full monthly premium cost to stay on the City's health insurance.

Terms To Know

Deductible

The amount ***you pay*** out of your pocket each year ***before the plan begins*** sharing costs for most services. Payments to in-network and out-of-network providers count toward your annual deductible and annual out-of-pocket maximum.

Out-of-Pocket Maximum

The most you'll have to pay out of your pocket in a calendar year for covered services.

Coinsurance

The cost share between you and the plan after you meet the calendar year deductible. In other words, after you meet your deductible, you share any remaining covered expenses with the plan, up to the out-of-pocket maximum. The plan covers the percentage of the expense shown.

In-Network Coinsurance

Plan Pays 80%

****

You Pay 20%

Being a good consumer of your benefits assists with reduced health care costs. Ways to assist with cost savings include but may not be limited to: avoiding Emergency Room visits for non-emergent needs, choosing generic pharmacy drugs where available, and being proactive in your own health and health maintenance.

Medical Plan Highlights

UMR	$1,750/$3,500 Deductible UHC Choice Plus Network	
	In-Network	**Out-of-Network**
Deductible (embedded)		
Single	$1,750	$3,500
Family	$3,500	$7,000
Out-of-Pocket Maximum		
Single	$6,000	$12,000
Family	$12,000	$24,000
Coinsurance	80%	50%
Physician Services		
Preventive Care	***Covered in Full***	Deductible & Coinsurance
Onsite Clinic	***Covered in Full***	N/A
Office Visit (PCP/Specialist)	$40 / $65	Deductible & Coinsurance
Hospital Services	Deductible & Coinsurance	Deductible & Coinsurance
Urgent Care	$100	Deductible & Coinsurance
Emergency Care	$500	
Prescription Drugs		
Retail 31 Day Supply	$10 / $50 / $75	
Specialty 30 Day Supply	30% to $300 Max	
Retail & Mail Order 84-93 Day Supply	$20 / $100 / $150	

Refer to the Summary Plan Description (SPD) or Summary of Benefits and Coverage (SBC) for detailed medical plan coverage information.

2026 Monthly Rates	*Total Monthly Premium*	*Monthly Employer Premium*	*Monthly Employee Premium*
Single	$819.26	$737.34	$81.92
Employee + Spouse	$1,884.32	$1,695.88	$188.44
Employee + Child	$1,474.68	$1,327.20	$147.48
Family	$3,277.06	$2,949.34	$327.72

The wellness incentive will continue to be independent of the premium.

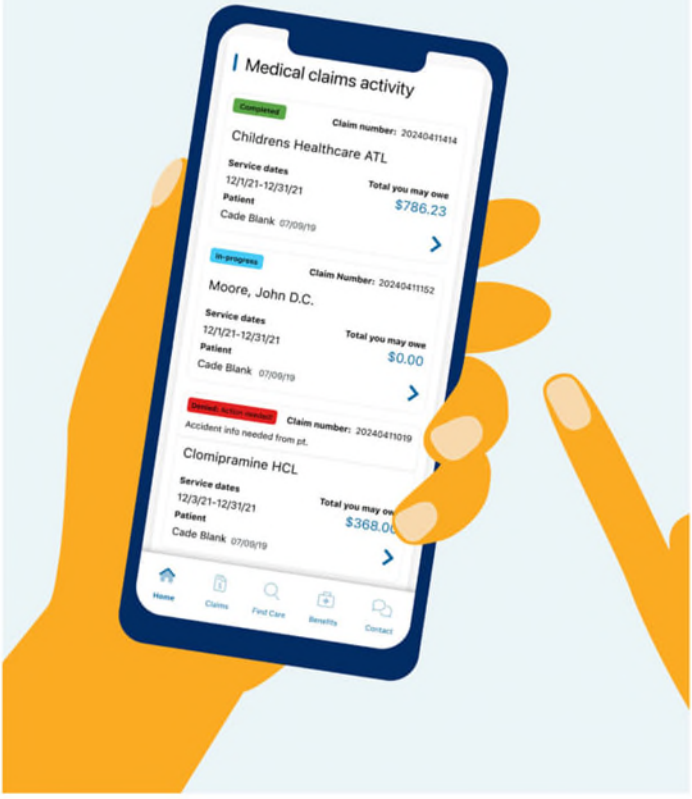
See Page 25 for details

Part-time employees who average more than 30 hours per week, but less than 37.5 hours per week are eligible to participate in health insurance by paying a prorated amount of the monthly cost of premiums based on their full-time equivalent (FTE).

Note: UMR is for Medical Only. Dental claims are not available through this resource.

Welcome to a smarter, simpler, faster way to manage your health care benefits, right from the palm of your hand.

UMR on the go!



The UMR app has a smart fresh look, simple navigation, and faster access to your health care benefits information. View your plan details on demand – anytime, anywhere.

With a single tap, you can:

- Access your digital ID card
- See a personalized list of **Things to do** to stay on top of your health and keep your benefits up to date
- Look up in-network health care providers
- Find out if there's a co-pay for your upcoming appointment
- View your recent medical and dental claims
- Chat, call or message UMR's member support team

Download the UMR app today!

Scan the QR code or visit your app store to get started.

UMR
A UnitedHealthcare Company

Find a provider

Finding a network provider on **umr.com** or the **UMR app** has never been easier

1

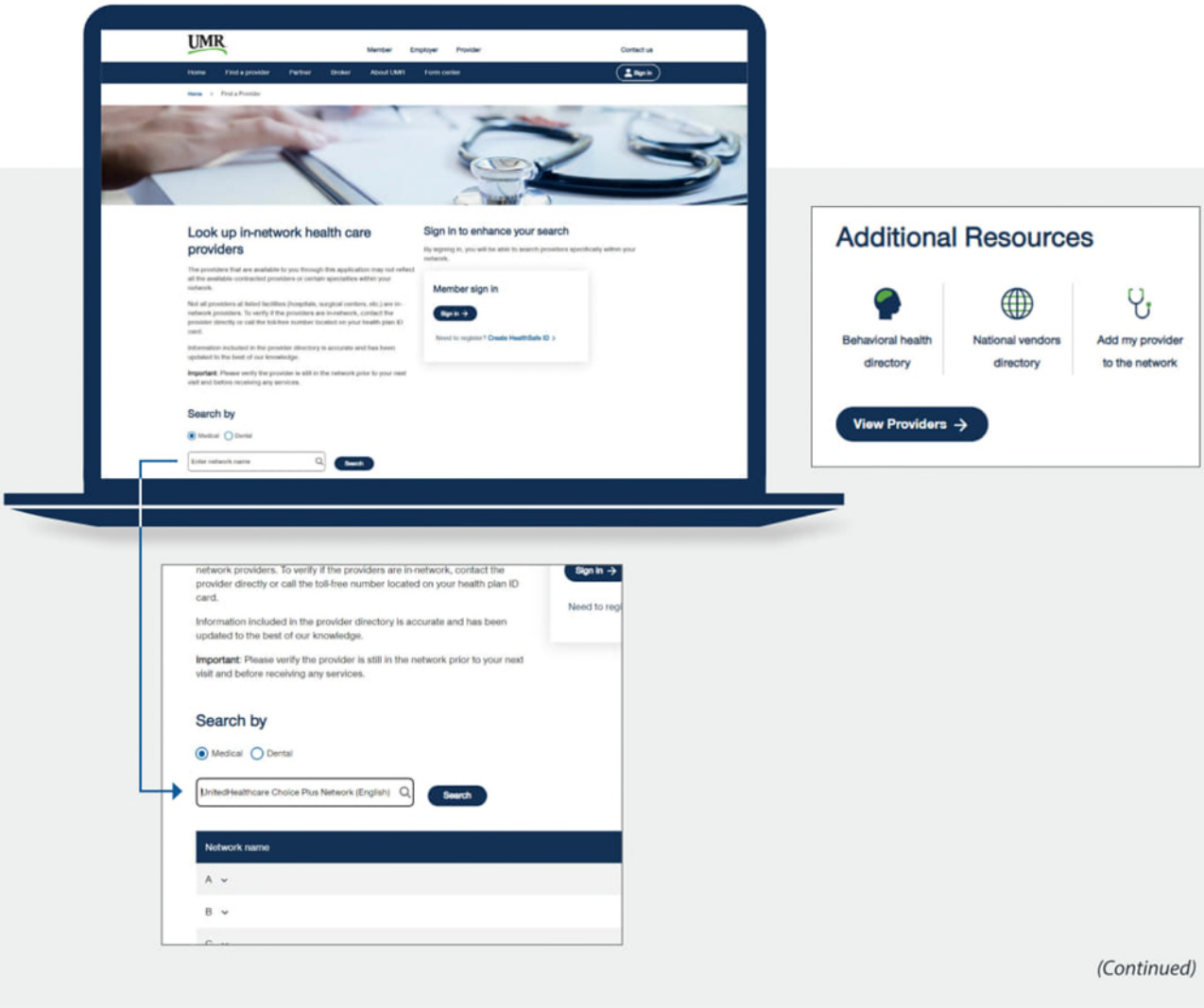
Go to **umr.com** and select **Find a provider**

2

Search for **UnitedHealthcare Choice Plus Network** using our alphabet navigation or type **UnitedHealthcare Choice Plus** into the search box

3

For medical providers, choose **View providers.** For behavioral health providers (including counseling and substance abuse), select **Behavioral health directory**



(Continued)

Manage your medication online and save time

The Optum Rx® website and app are fast, easy and secure ways to get the information you need to make the most of your pharmacy benefit.

Set up an online account to:

- Check drug prices
- Place a home delivery order
- Track home delivery order status
- Access and print your ID card
- Find a network pharmacy
- Sign up for automatic refills
- View claims and benefit information

Register now

To set up your online account:

1. Go to **OptumRx.com** or scan the QR code below
2. Select Register on the home page
3. Enter the information from your member ID card
4. Create a username and password
5. Complete your profile

If you already have an account, sign in using your username and password.

Scan here to go to **OptumRx.com**

Skip the pharmacy line

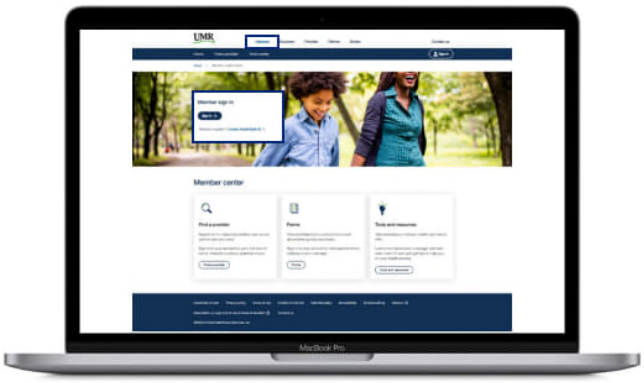
Transfer eligible maintenance medications to Optum® Home Delivery and get a three-month supply delivered right to your door.

Optum Rx®

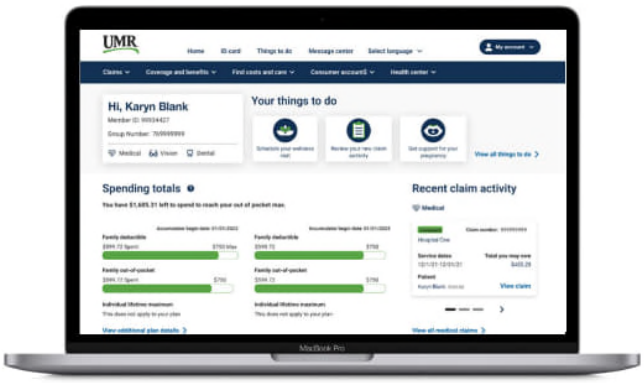
UMR members can access their prescription information from the UMR website

Follow these steps to register:

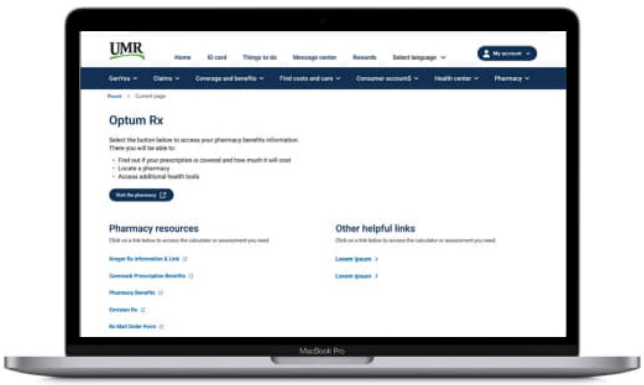
1. Visit **umr.com.**
2. At the top of the home page, select Member.
3. On the next page, select Member sign in and then sign in using your username and password. If you're new to the site, select Create Healthsafe ID to set up your account and sign in.



4. After signing in, go to Pharmacy drop-down and select Visit the pharmacy to go to pharmacy home page.



5. On the pharmacy home page, select the Visit the pharmacy button to go to **optumrx.com** and take advantage of the tools and features that will help you manage your pharmacy benefits.



On your first visit, you will also need to register at **optumrx.com** just follow the simple instructions.

Maximize your health benefits

When you need a physician, maximize your health plan benefits by making sure the physician you choose has the UnitedHealth Premium Care Physician designation for quality of care and cost efficiency.

Finding the right physician is the most important thing you can do for your health care…

But it isn't always easy. We provide the information you need to help you make a more informed decision on where to seek care.

… and now, for your pocket book.

When you visit a physician who has UnitedHealth Premium designations for quality and/or cost efficiency, you may pay lower co-payments for office visits, and get higher plan co-insurance coverage.

TIER 1 Look for the blue Tier 1 dot.

It's important to choose carefully.

To get the most from your plan, find a quality efficiency designated physician by visiting **umr.com** and click on Find a Physician or Facility. Look for a physician with the Premium Care Physician designation.

Your ID card includes a Customer Care phone number for easy access to designation information.

TIER 1

To find a UnitedHealth Premium-designated doctor, just look for the Tier 1 physician designation.

Understanding Your Care Options

Proactively understanding your care options can have a big impact in the amount you pay out-of-pocket when seeking care. The chart below is intended to help you identify the right setting for your specific needs.

Type of Care	Common Services		Approximate Wait Time	Average Member Cost
Teladoc	o Poison Ivy o Pink eye o Sinus Problems	o Allergies o Cold or flu o Bronchitis	**15** Minutes	**$0**
Onsite Clinic	o Flu Vaccines o Routine Lab Services o Allergies o Cold Sores	o Ear Infections o Health screenings o Strep Throat o Minor Sprains	**Same Day / Next Day** Availability	**$0** (All benefit eligible employees) **$40** (Opt-Out Dependents)
Retail Clinic	o Colds or flu o Sinus Infection o Allergies o Minor cut	o Vaccinations o Screenings o Minor sprain o Minor burn	**15** Minutes	**$40**
Your Doctor's Office	o Preventive services o Vaccinations o Ongoing condition management	o Medical problems that are not an immediate, serious threat to your health or life	**1 Week** or More	**$40** *Primary Care Provider* **$65** *Specialist*
Urgent Care	o Sprains or strains o Mild asthma attack o Sore throat o Earaches	o Minor broken bone o Minor cut o Minor infection o Minor rash	**20 – 30** Minutes	**$100**
Emergency Room	o Sudden change in vision o Sudden trouble talking o Large open wounds o Major burn	o Severe head injury o Heavy bleeding o Chest pain o Major broken bone	**3 – 12** Hours	**$500**

Teladoc HEALTH

General Medical: What to know about this benefit

Did you know 60% of patients have to wait 2 weeks to see their primary physician and only 10% are able to get in to see their regular doctor the same day they need care?[1]

Our Teladoc Health benefit gives you access to compassionate care from U.S. board certified clinicians, anytime, anywhere. Providers are available in all 50 states and you can meet with them 24/7 by phone or video.

The average Emergency Room care costs 10 times more than an urgent care visit for the same diagnosis.[2]

Teladoc Health can help you skip the trip to the ER or urgent care for non-emergency problems, avoid long wait times and save money since you can see a clinician within minutes by phone or video. Teladoc Health is here to listen, answer your questions and help you feel better faster.

- **What services does Teladoc Health provide?** Teladoc Health provides healthcare for the whole you and can help you with everyday, non-emergency health needs like prescription refills, coughs, colds, UTIs, sinus, allergies and much more. Teladoc Health helps you get healthy and live healthy.
- **How much does Teladoc Health cost?** Your out of pocket cost varies based on your plan. If you do have to pay, you will see your cost before you finish requesting your visit. You can pay with a credit card, prepaid debit card, HSA (health savings account), or by PayPal.
- **How do I sign up?** To sign up for Teladoc Health, scan the QR code below to download the app, call 1-800-835-2362, or visit the website. Visits can be by phone or video and there is no time limit on how long the visit is.
- **How does it work if I am traveling and not in the state I live in when I need help?** Teladoc Health is available in all 50 U.S. states, so the service can be used even if you are traveling. Some restrictions may apply.
- **Can Teladoc Health providers prescribe medicine?** Yes they can when it makes sense medically. But, Teladoc Health providers do not prescribe controlled substances, drugs like Viagra and Cialis, and/or other drugs that have a higher risk of abuse. If a prescription is not needed, the Teladoc Health provider may give you instructions for managing symptoms.

Call 1-800-835-2362

Visit Teladoc.com | Download the app

[1] https://plus.credit-suisse.com/rpc4/ravDocView?docid=V7r1Oh2AN-ZqC1
[2] https://www.ucaoa.org/LinkClick.aspx?fileticket=Q4TP7cypW94%3D&portalid=80

network health

FAMILY SAVINGS PLAN™

Network Health offers an innovative health plan option called the Family Savings Plan. The Family Savings Plan allows you and your family the opportunity to have up to 100 percent coverage for eligible out-of-pocket expenses.

FOR EMPLOYEES

If you and/or any member of your family is currently enrolled in your employer's medical plan, and you, your dependents (children) or spouse has access to another employer-sponsored plan (which may be your spouse's), you may take advantage of the Family Savings Plan by transitioning to the other employer-sponsored plan.

Answer these two simple questions to determine if you could be eligible for the Family Savings Plan

Do you, your spouse or dependents have access to coverage through another employer's plan?

YES

Are you, your spouse or dependents currently enrolled in your company's medical plan?

YES

You, your spouse or dependents may be eligible to enroll in the Family Savings Plan.

NO

You, your spouse or dependents are not eligible to enroll in the Family Savings Plan.

NO

You, your spouse or dependents are not eligible to enroll in the Family Savings Plan.

The Family Savings Plan allows enrollees to be reimbursed up to **100 percent** for eligible out-of-pocket costs.
This type of coverage is rare in today's health insurance market.

Frequently Asked Questions

What is the Family Savings Plan?

The Family Savings Plan is an enhanced benefit that may allow you and your family to be reimbursed up to 100 percent for eligible out-of-pocket health care expenses (including copayments, coinsurance and deductibles) received under another employer-sponsored plan (which may be your spouse's), if the following requirements are met:

- Coverage under your employer's plan is waived (when you enroll in the other plan)
- Services are covered under the other employer sponsored medical plan

Who is not eligible for the Family Savings Plan?

If you are not currently enrolled in your employer's medical plan, you're not eligible to enroll in the Family Savings Plan. The plan is also not available if the other employer-sponsored plan is one of the following:

- High Deductible Health Plan (HDHP) with **active** contributions to a health savings account (HSA)*
- Medicare, Tricare or Medicaid
- Individual plan purchased on or off the Health Insurance Exchange (also known as the Marketplace)
- A stand-alone health reimbursement account (HRA), not paired with a medical plan
- Short-term individual coverage
- Limited Benefit Health Plan under IRS rules

* If HSA employer and employee contributions are **not active** or are discontinued, you, your spouse or dependents may be eligible for the Family Savings Plan.

What if the premium of the other employer-sponsored plan costs more than the premium with my employer's plan?

You may be reimbursed a premium differential if the alternate plan's premium is higher. The reimbursement is considered taxable income.

What does the Family Savings Plan cover?

Covered services are determined by the other employer plan. Family Savings Plan enrollees are reimbursed for all eligible copayments, coinsurance and deductibles incurred up to the maximum out-of-pocket limits as set by your employer. Reimbursed claims are not taxable income to Family Savings Plan enrollees.

What if the other plan charges a fee for me to join?

If the other employer-sponsored plan charges a fee to add you to the plan, you may be reimbursed for that fee. This reimbursement is considered taxable income.

When can I, my spouse or dependents enroll in the Family Savings Plan?

You, your spouse or dependents may enroll during the following times:

- Annual open enrollment period
- Following a qualifying life event
- During a spouse's or dependents' open enrollment period (if the Family Savings Plan is voluntary, enrollees may need to wait for this open enrollment period)
- As a new employee

What if my spouse is self-employed and is currently covered as a dependent under my employer's plan? Would we be eligible for the Family Savings Plan?

No, you and your spouse would not be eligible, because your spouse does not have access to medical coverage through another employer-sponsored plan.

What if my spouse is not covered under my employer's plan, but they are on a Medicare plan?

Medicare is not an employer-sponsored medical plan, therefore, you and your spouse would not be eligible for the Family Savings Plan.

How do Claim Reimbursements work?

- When you see a medical provider or go to the pharmacy, present the primary medical plan ID card as primary, then present the Family Savings Plan ID card as secondary.
- If the Family Savings Plan ID card is accepted the payment is sent directly to the provider or pharmacy.
- If the provider or pharmacy does not accept the Family Savings Plan ID card, you will need to submit the Explanation of Benefits (EOB) or the detailed pharmacy receipt. Options for a member claim submission are the FSP portal, secure email, fax or mail.

How long will it take to be reimbursed for claims?

Reimbursements are typically processed within 30-60 days.

FSP and Health Plan 2026 Open Enrollment

Who This Applies To:

- **Active employees currently enrolled in the City's health plan**
- **Employees eligible for the City's health plan who have access to other coverage**

Note: The Family Savings Plan (FSP) is an alternative to the City's current opt-out program. See below for details on the grandfathered plan and the alternative Family Savings Plan.

Eligibility & Options

Grandfathered Opt Out Program:

- For employees enrolled in the 2025 opt-out benefit:
  - $1,250 for employee-only coverage
  - $2,500 for family coverage
- Must be enrolled in an alternate employer group health plan
- Employees and family members cannot enroll in the City health plan or FSP under this option
- Grandfathered for current participants; not available to new enrollees

Family Savings Plan (Alternative to Opt-Out):

- Available to new hires or employees previously enrolled in the City health plan
- Enroll in an alternate employer-sponsored health plan and the FSP
- Reimbursement for covered medical and pharmacy expenses up to ACA limits:
  - $10,600 per individual
  - $21,200 per family
- Taxable premium incentive:
  - $50/month for 1 member off the City plan
  - $100/month max for multiple members off the plan
- All family members moving to FSP must enroll during open enrollment to qualify.

Important Notes

- FSP is only for active employees
- Does not continue after retirement
- No City contributions to premiums or out-of-pocket costs if coverage is obtained through the marketplace or another plan after leaving the City's coverage
- FSP is a transition benefit for employees with alternative coverage during employment

Employee Clinic

We recognize that creating a healthy workplace is more than just talking about the benefits of living a healthy lifestyle. It's about providing an environment and opportunities to make that happen. That's why we are proud to provide you onsite access to primary care services through our partnership with ThedaCare.

All benefit eligible employees are eligible to utilize the employee clinic at no cost to you. Dependents (ages 2-26) who are enrolled in the City's health insurance are eligible to receive care at our onsite clinic at no charge. Those dependents not on the City's health plan may receive care for a $40 co-pay per visit.
Note: For opt out employees and dependents, this is considered an out-of network provider and associated labs and/or prescribed medications may not be covered through your primary insurance.

Cost of Care:

Benefit Eligible Employees: ***FREE of CHARGE***
Dependents under City Health Plan: ***FREE of CHARGE***
Spouse & Dependent Opt Outs***: $40 Fee***

General Services For…

- Regular physical exams
- Prescription of medications
- Treatment of minor injuries
- Treatment of minor illnesses
- Health screenings for common health problems

Advanced Care Clinic

Gina Rekers
APNP, FNP-C

City of Neenah Employer Clinic
211 Walnut St. Neenah, WI
(920) 886-6155

Monday: 8:00 am – 5:00 pm
Tuesday: 7:00 am - 3:00 pm
Thursday: 8:00 am - 5:00 pm
Friday: 7:00 am – 3:00 pm

Hours may vary due to City Hall hours of operation

Your Care Starts With Us

Your solution to convenient, accessible and high quality care. Advanced Care services through ThedaCare At Work offers a customized team-based approach from prevention to acute care and chronic condition management. Option to designate our provider as your Primary Care Provider or partner with your Primary Care Provider to help you live your unique best life.

- Physicals (Annual, Sports, Camp, Pre-op)
- Care for Minor Illnesses, Injuries, and Concerns
- Chronic Condition Management
- Care Coordination
- Medication Management
- Lifestyle Education & Coaching
- Tobacco & Alcohol Cessation
- Referral to Specialty Services & Preventative Testing
- Depression & Anxiety Screening and Treatment
- Simple Medical Procedures (Warts, Skin Tags, Ear Flushes)
- Vaccines, Labs & Rapid Testing (per company discretion)

Scan me to schedule

Wellness Incentive Benefit

Health Reimbursement Account (HRA)

Employees and covered spouses who submit proof of an annual preventive exam qualify for a contribution to a Health Reimbursement Account (HRA) account in the amount of $200 each, up to $400 per year.

To qualify for the Wellness Benefit, employees and eligible spouses must submit documentation to reflect you have completed an annual preventive exam.

Deadlines to submit documentation of your annual preventive exam will be **December 15th** and must reflect an exam date within a 12-month look back period for the 2026 plan year. Submissions received **after December 15th but before January 31st** will still be accepted but may be delayed when being applied to your account.

Submissions received after February 1 will be applied to the 2027 plan year.

Some exceptions may be made due to scheduling restrictions. Employees unable to secure an appointment for such documentation must contact **Human Resources by December 15, 2025,** to notify the office of the status of said appointment.

Employees using the employee clinic for such services are recommended to utilize either their birth month or hire month as a guideline for scheduling. Such guidelines assist with clinic availability.

Wellness Incentive Contributions:
Language as outlined above included here:

Employee Amount	*$200 Annually*
Covered Spouse Amount	*$200 Annually*
Total Wellness Benefit Maximum	*$400 Annually*

HRA money is available at the beginning of the calendar year in the full amount specified provided documentation has been received by the deadline date. **Any unused HRA money is rolled over into the next year.**

HRA Funds after Termination of Plan

Employees will have 60 days after termination to submit qualified HRA expenses incurred while an active employee and covered under the employer's group health plan. Otherwise, qualified beneficiaries of the employee will not have access to the HRA unless they elect continuation of the HRA through COBRA (up to 36 months should an employee pass away).

Flexible Spending Account (FSA)

With an FSA, you can set aside tax-free money to pay for eligible expenses. When you participate in an FSA, you decide how much you want to contribute each plan year (Jan. 1 through Dec. 31). The amount you contribute this year may look different than in previous years due to the lower deductible plan with copays, and the change in the HRA structure this year. The money you contribute is deducted from your pay before taxes are taken out. ***This lowers your taxable income, which means lower taxes for you!*** However, you must use the amounts in your account by year-end or lose the balance.

City of Neenah offers three types of FSAs administered by Diversified Benefit Services.

General Purpose FSA

You can use this FSA to pay any qualified health care expense, including copays and deductibles, dental care and vision care. You're ***not*** eligible for the General Purpose FSA if you are currently contributing to a Health Savings Account.

Limited Health Care FSA

The expenses that are reimbursed by this FSA are limited to dental and vision care expenses in the plan year only.

General Purpose & Limited Health Care FSA Contribution Limits

The City of Neenah follows the indexed contribution limits set for this type of account by the Internal Revenue Service (IRS). The contribution limits for both the General Purpose FSA and Limited Health Care FSA work on an individual employee/financial representative basis. The individual maximum in 2026 is $3,400. A maximum of $680 can be carried over into the 2027 plan year.

Dependent Care FSA

The Dependent Care FSA covers the eligible day care expenses for your tax-qualified dependent(s). This can include a tax-qualified dependent under the age of 13 or an elderly parent or spouse who is physically or mentally incapable of self-care and lives with the account owner.

Unmarried individuals and married couples who file a joint tax return can contribute up to a maximum of $7,500 in 2026. Individuals who are married and file taxes separately can contribute up to a maximum of $3,750 in 2026. You cannot contribute more than you or your spouse earned in income for the year. ***If you're enrolling during the year, you may not be eligible to make the maximum contribution to your FSAs. Talk to your tax advisor before signing up for pretax deductions. See IRS Publication 502 for more information.***

DIVERSIFIED BENEFIT SERVICES, INC.

Excellence in Benefit Management Solutions

Flexible Benefit Plan Expense Worksheet

Use this worksheet to estimate your expenses. Plan Year: _____/_____/_____ to _____/_____/_____

Dependent Care FSA

Consider what expenses you will have in the next plan year for dependent care such as day care, adult care, etc. to allow you or your spouse to work or attend school full time. This is for dependents under the age of 13, adult dependents or other legal dependents.

Total Annual Amount $_____

Health Care FSA

Consider what expenses you and/or your spouse and legal dependents will have during the upcoming plan year that will not be paid for by insurance. Also look at what expenses you had during the past year or two and give a conservative estimate for what they might be for the upcoming plan year.
(Expenses must be incurred, which means having a date of service—not paid for—during the plan year.)

Health insurance deductible (not including premiums) $_____

Co-pays for medical expenses $_____

Dental insurance deductible $_____

Dental expenses such as exams, cleanings, fillings, caps, crowns, braces, bridges, x-rays, etc. $_____

Vision expenses such as exams, glasses, frames, contact lenses, supplies or LASIK surgery $_____

Hearing aids (including batteries) $_____

Prescription drugs $_____

Over-the-counter (OTC) drugs such as allergy and anti-inflammatory drugs, cold and flu medications, muscle relaxants, pain relievers, cough suppressants and acid reflux medications $_____

Other expenses (see additional expenses below) $_____

Total Annual Amount $_____

Additional Eligible Expenses for the Health Care FSA

- Acupuncture
- Alcoholism treatment
- Ambulance service fee
- AODA assessment
- Artificial teeth—medically necessary
- Artificial limbs
- Bandages
- Birth Control by prescription (and/or over-the-counter contraceptives)
- Braces/Orthodontia
- Braille—books and magazines
- Breast pump and supplies
- Car controls for the disabled
- Care for mentally handicapped child
- Chiropractic expense
- Co-insurance amounts you pay
- Contact lenses
- Contact lens solutions and enzyme cleaners
- Cost and repair of special telephone equipment for the hearing-impaired
- Cost of medically necessary operations and related treatments
- Crutches
- Dental fees such as X-rays, cleanings, exams or crowns
- Dentures
- Diabetic supplies
- Diagnostic fees
- Disposable contact lenses
- Eye examinations
- Eyeglasses
- Fee for in-home practical nurse
- Hearing aid devices and batteries
- Hospital services
- In-patient treatment expense for drug and alcohol addiction
- Insulin
- KeraVision Intacs surgery
- Laboratory fees as prescribed by a physician
- LASIK surgery
- Mammograms
- Medical deductibles
- Medical services
- Medical supplies (medically necessary)
- Menstrual care products
- Mentally handicapped person's cost for special home nursing services for in-home care (including nurses' meals and Social Security tax)
- Mileage for medical care
- Obstetrical expenses
- Organ donor transplant medical expense payments for surgical, hospital, laboratory and transportation expenses
- Orthodontia
- Orthopedic inserts
- Osteopath fees
- Over-the-counter (OTC) drugs
- Oxygen and medically necessary oxygen equipment
- Physician fees
- Physician-prescribed swimming pool or spa equipment costs and maintenance due to medically necessary reasons
- Prescription drugs
- Psychiatric care
- Psychologist fees
- Radial keratotomy
- Routine physicals
- Seeing eye dog and its upkeep
- Smoking cessation programs
- Special education for the blind
- Special plumbing for the handicapped
- Special school for mentally impaired or physically disabled person
- Sterilization fees
- Surgical fees
- Television audio display equipment for the hearing-impaired
- Therapy treatments for medically necessary reasons
- Transportation expenses primarily for and essential to rendering special medical services as prescribed by a physician
- Vitamins and nutritional supplements (with pre-approved letter of medical necessity from physician)
- Weight loss program fees (with pre-approved letter of medical necessity from physician)
- Wheelchair
- X-rays

Expenses NOT Eligible for Reimbursement

Surgery for cosmetic reasons

Medical supplies that are not medically necessary

Teeth bleaching/bonding/whitening

Health club membership dues

Over-the-counter vitamins and other dietary supplements for general health purposes

Cosmetic drugs

Marriage counseling

Group insurance premiums deducted from your paycheck

Your Estimated Plan Year Savings

Total plan year elections for the above categories: $_____

Multiply by approximately 30% (estimated tax savings): x 30%

This is your estimated tax savings for the plan year: $_____

(Your savings may be different due to your effective income tax rate)

Note: If further verification is needed regarding whether an expense qualifies, please call our office at (800) 234-1229. Consult your tax advisor for maximum benefit. It is understood that Diversified Benefit Services, Inc. is not engaged in the practice of law or giving tax advice.

Dental Plan Highlights

Healthy teeth and gums are an important part of maintaining your overall health.

Delta Dental	**Delta Dental** PPO and Premier Benefits	**(NEW) CarePlus Dental** Dental Associates & Midwest Dental
Individual Annual Maximum	$2,000	$2,500
Deductible		
Employee Only	$25	$0
Family	$75	$0
Preventive Care Services		
Exams	100%	100%
Cleanings	100%	100%
Fluoride Treatments	100%	100%
X-Rays	100%	100%
Space Maintainers	100%	100%
Basic Restorative Services		
Sealants	80%	100%
Emergency Treatment to Relieve Pain	80%	80%
Fillings	80%	80%
Crowns	80%	80%
Endodontics – Surgical / Non-Surgical	80%	80%
Periodontics – Surgical / Non-Surgical	80%	80%
Extractions – Surgical / Non-Surgical and other oral	80%	80%
Major Restorative Services		
Bridges and Dentures	50%	80%
Repairs and Adjustments to Bridges and Dentures	50%	80%
Implants	50%	80%
Orthodontic Services		
Coinsurance	50%	50%
Maximum	$1,500 (Annual)	$2,500 (Lifetime)
Dependents Eligible to Age	26	26
Adult Ortho	Yes	Yes

See Page 9 of this guide for rate details

Scan the QR code to view
Dental Associates Clinic Locations

Networks and providers

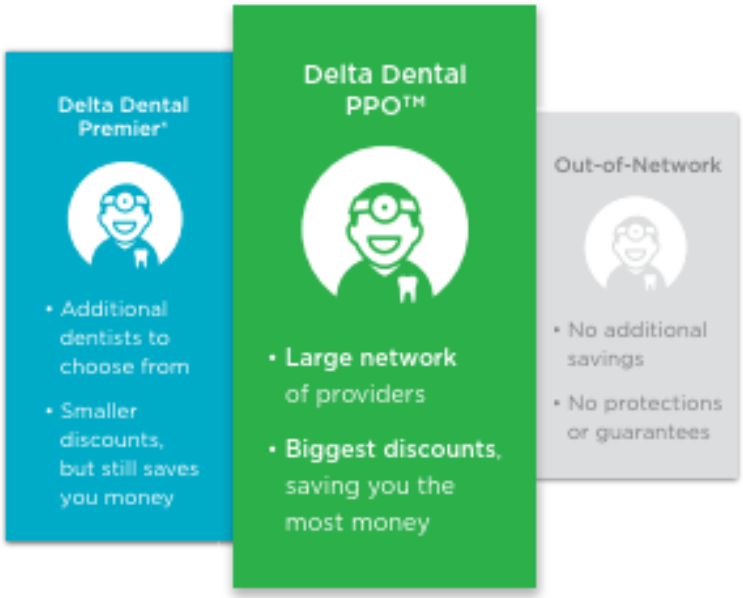
You can see any provider you like. However, you'll save money if you see an in-network dentist. We have two networks: Delta Dental PPO (these dentists provide the largest discounts to save you the most money) and Delta Dental Premier (additional providers to choose from, but they offer smaller discounts). Together they make the Delta Dental PPO Plus Premier™ network with almost 151,000 providers nationwide to save you money.

But if you don't have a provider, or would like to find one who saves you more on out-of-pocket expenses, use our online provider search tool at deltadentalwi.com.

Other benefits (no pun intended) of using a network provider:

- Treatment guarantees* (if a procedure like a filling fails, you don't have to pay to get it fixed)
- Providers send in all the claims paperwork, so you don't have to
- Since network dentists agree to set fees, they can't charge you for the difference between their regular and discounted amount (called balance billing)

Know your networks



Example savings for a common procedure

	Estimated charge	Maximum allowed fees	Percentage paid by Delta Dental	Amount Delta Dental pays	Amount dentist can balance bill	Total amount you pay	Your total cost savings
PPO network	$1,200	$825	80%	$660	$0	$165	$375
Premier network	$1,200	$985	80%	$788	$0	$197	$215
Out-of-network**	$1,200	$925	80%	$740	$275	$460	$0

*Guarantees dependent upon timeframes and procedure codes.
**If you visit an out-of-network provider you will be responsible for the difference between the provider's charges and the amount your dental plan pays.
Always check your benefit summary/plan documents to verify coverages. Regardless of the provider you see, you will be responsible for your plan's deductible, coinsurance, and fees for services that are not covered under your plan.

DELTA DENTAL®

Smarter Dental Plans

Enhanced dental benefits for those who need them most.

Your dental coverage includes Delta Dental of Wisconsin's Evidence-Based Integrated Care Plan (EBICP), which provides **additional cleaning(s) and/or fluoride treatments to individuals with specific medical conditions** that have oral health implications. Enhanced benefits can play an important role in the management of certain medical conditions.

If you or an individual on your plan have one or more of these conditions, you can enroll online. Once you enroll, you are immediately eligible for EBICP benefits.

How to enroll

1. Go to **www.deltadentalwi.com.**
2. Select the purple "Sign In" button and enter your Username & Password.
3. On your dashboard under "Preventive Care and Plan Features" there will be a section for Additional Benefits. Select "Enroll Now."*
4. In the "Enroll in EBICP" section, select the member and their condition, verify the information, and hit "Select."
5. This member will then be listed under "Your Current EBICP Benefits."

Condition	Additional cleaning(s)	Topical fluoride
Cancer-related treatments	✓	✓
Weakened immune systems	✓	✓
Periodontal (gum) disease*	✓	✓
High-risk cardiac conditions	✓	
Kidney failure or dialysis	✓	
Diabetes	✓	
Pregnancy	✓	

This chart provides a brief summary of additional benefits to persons enrolled in EBICP. Frequency limitations may apply. Refer to your handbook.

**Periodontal cleanings may fall under basic services and may not be covered 100% by the EBICP plan. If you have questions regarding coverage for periodontal cleanings, please contact the Benefit Center at 800-236-3712 before services are performed.*

Open the camera on your smartphone and scan the QR code to learn how EBICP can help each condition, or visit *deltadentalwi.com/EBICP*

*If your plan does not include EBICP, "Additional Benefits" will not show.

Connect With Us

deltadental.com

SS300H(QR)-2502

Any questions?

Here are some answers. And if you have a question that's not listed here, contact us. You can call our Contact Center at **800-236-3712**. Or avoid a phone call...if you're logged in to your online account (see previous page) you can secure message or even live chat with a representative.

But see if these help...

Q: When will I get my ID card?

A: Your ID card will be mailed about a week after your enrollment is received and approved. If you are already a member, you can login to your online member account at **deltadentalwi.com** to view, print, or even email your ID card at any time.

Q: Are there benefit waiting periods?

A: Unless otherwise specified, there are no waiting periods before you can start using your dental benefits.

Q: What about existing orthodontic treatments in progress?

A: Delta Dental's monthly payments for ortho treatment will work toward the months remaining after your effective date of coverage. Claims for in-progress ortho can be submitted as soon as enrollment with Delta Dental is finalized.

Your Hearing Program

If you have noticed changes in your hearing, rest easy.

Delta Dental of Wisconsin has teamed up with Amplifon to offer you quality hearing care.

	Level 1	Level 2	Level 3	Level 4	Level 5
	Hearing aid options from the top brands with an average savings of 66% off retail pricing.*				
Amplifon Price (per ear)	**$995**	**$1,295**	**$1,495**	**$1,895**	**$2,195**

Virtual services

Virtual screening – determine need from the comfort of home

Personalized coaching – enhance adjustment and use of hearing aids

On-demand virtual visits – convenient care for non-clinical support

60-day risk-free trial

Find your right fit by trying your hearing aids risk-free

Complimentary aftercare

1-year follow-up care - ensures smooth transition to your new hearing aids

2-year battery support - battery supply or charging station to keep you powered

3-year warranty - coverage for loss, repairs, or damage

To learn more:

Call 888-901-0132 (TTY: 711) | Hours: Mon-Fri 7am - 8pm CT

Visit amplifonusa.com/deltadentalwi

amplifon Hearing Health Care

DELTA DENTAL®

*Based on 2022 internal MSRP analysis. Your savings may vary.

You and your provider will determine the best device to meet your hearing loss, lifestyle, and technology needs. **Risk-free trial** - 100% money-back guarantee if not completely satisfied, no return or restocking fees. **Follow-up care** - for one year following purchase. **Batteries** - two-year supply of batteries (80 cells/ear/year) or one standard charger at no additional cost. **Warranty** - exclusions and limitations may apply. Contact Amplifon 888-901-0132 for details. Virtual screening does not take the place of a diagnostic exam by a licensed professional. Not all virtual services are available on all products.

Amplifon Hearing Health Care is solely responsible for the administration of hearing health care services, and its own financial and contractual obligations. Delta Dental of Wisconsin and Amplifon are independent, unaffiliated companies. Hearing services are administered by Amplifon Hearing Health Care, Corp. The Amplifon Hearing Health Care discount program is not approved for use with any third-party payor program, including government and private third-party payor programs. Hearing services are administered by Amplifon Hearing Health Care, Corp.

Vision Plan Highlights

Your eyes provide doctors with a clear picture of your overall health. A comprehensive eye exam can identify serious medical problems such as high blood pressure, diabetes, heart disease and much more.

Delta Vision *(Insight Network)*	**In-Network Benefit**	**Out-of-Network Reimbursement**
Frequency *(based on calendar year)*		
Vision Exams	12 Months	
Frames	24 Months	
Lenses or Contacts	12 Months	
Annual Vision Exam	Member pays $10	$35
Standard Plastic Lenses		
Single Vision	Member pays $10	$25
Bifocal	Member pays $10	$40
Trifocal	Member pays $10	$55
Standard Progressive	Member pays $75	$40
Contact Lens Fit & Follow-Up		
Standard	Member pays up to $40	None
Premium	10% Discount off Retail	None
Allowance Summary		
Frames	$150, then 20% off Balance	$75
Conventional Contacts	$150, then 15% off Balance	$120
Disposable Contacts	$150	$120
Medically Necessary Contacts	Paid in Full	$200

Monthly Rates	**Employee Cost**
Employee	$6.56
Employee + Spouse	$13.12
Employee + Child(ren)	$11.80
Family	$17.30

Why you need vision insurance

Healthy vision couldn't be more important, but unfortunately vision disorders are one of the top ten disabilities in the U.S.[1] That's why Delta Dental of Wisconsin is happy to bring you DeltaVision benefits that offer more flexibility, choice, and savings—so that it's easy for you to access the vision care and services you need. DeltaVision's coverage for contact lenses and glasses, and discounts for services like laser vision correction, help you take care of your eyesight for less.

For your budget

You can save more than 70% off retail pricing when using your vision benefits.

For your health

An estimated 93 million U.S. adults have a high risk for serious vision loss.[1]

For your family

Up to 25% of school-age children may have vision problems. Children need to see well to learn well.[2]

Immediate savings

See how much you'd pay without vision insurance for an exam and eyeglasses**...and how much you can save.
Based on a plan with a $150 frame allowance with 20% off balance of frames, and $0 exam/copayment.

Service/Material	Average retail cost	DeltaVision covers	Member pays
Exams*	$122	$122	$0
Frames ($150 allowance with 20% off balance of frames)	$188	$150 + $7.60	$30.40
Eyeglass lenses single-vision**	$87	$87	$0
Lens options – UV coating	$22	$7	$15
Standard scratch resistance	$27	$12	$15
Anti-reflective coating	$73	$28	$45
TOTAL	**$519**	**$413.60**	**$105.40**

**Not all plans include exam coverage. Refer to Your Vision Benefits to see if your plan includes exam coverage. Other plan designs or options may produce different out-of-pocket amounts.*

***Contact lenses may be selected in lieu of eyeglass lenses.*

[1] *https://www.cdc.gov/vision-health/data-research/vision-loss-facts/index.html*

[2] *https://www.aoa.org/healthy-eyes/eye-health-for-life/school-aged-vision*

Additional benefits

Diabetic benefits

Regular eye exams assist with the early detection of diabetes and can help treat or prevent glaucoma, diabetic retinopathy, and macular degeneration. DeltaVision allows for an office visit and diagnostic testing twice per year for those with diabetes to monitor signs of diabetic ocular changes. Medical follow-up exams, retinal imaging, scanning laser procedures, and more are also covered benefits.

Blue light lenses

Blue light-filtering lenses or anti-reflective coatings can help with the blurry vision, difficulty focusing, dry and irritated eyes, and headaches that come from using digital devices. DeltaVision members have the option to choose lenses and lens coatings with blue light-filtering technology. With a prescription to correct vision, DeltaVision members have the option to choose lenses

More ways to save

Exclusive savings, discounts, and rebates on vision care and services above and beyond your vision benefit are available for members at **deltavisionwi.com** under "Special Offers." New and updated offers are added quarterly and annually, so there's always more ways to benefit from your DeltaVision coverage.

Networks and providers

Delta Dental of Wisconsin is proud to work with EyeMed® Vision Care as the network provider for members enrolled in a DeltaVision plan. EyeMed networks are among the nation's largest provider networks, featuring popular retail chains and many small independent doctors.

Find a provider

- Go to **deltadentalwi.com** and select "Find A DeltaVision Provider."
- Select your network (found on your ID card or benefit summary).
- Enter your ZIP code on the "Find an eye doctor" screen, then click the "Search by ZIP" button.
- Providers in your network will appear sorted by distance from your ZIP code. You can further narrow your search by using the "Filter" options button.

You can also find provider information by calling EyeMed's dedicated DeltaVision line at **844-848-7090.**

Ancillary Benefits (Provided by The Standard)

Voluntary benefits provide the opportunity to customize your benefit package to meet your unique needs. There are a variety of options to choose from - all of which offer you affordable protection through the convenience of payroll deductions. See your enrollment information for details.

Voluntary Accident Insurance

Your medical insurance will cover some of the expenses incurred from an accident, but you'll be left to foot the bills for your copays and deductible. Those can add up fast, especially if you're unable to work while you recover. That's where Accident insurance comes in. It helps protect your bank account from the out-of-pocket expenses that come with an injury. Whether you're coping with a broken arm or recovering from a serious car accident.

Covered Injuries

- Broken bones
- Burns
- Cuts
- Torn ligaments
- Eye injuries
- Accidental Death

Voluntary Critical Illness Insurance

You may have medical insurance. But that doesn't mean you're covered for all of the expenses resulting from a serious illness that you probably haven't budgeted for. Things like copays, deductibles, loss of income, child care and travel expenses. Critical Illness insurance helps fill the gap caused by these out-of-pocket costs, creating a financial safety net for you and your family.

Covered Conditions

- Heart Attack
- Stroke
- Cancer
- Major organ failure
- End state renal (kidney) failure

NOTE: *initial diagnosis and initial recommendation must occur after your coverage for these benefits becomes effective.*

Voluntary Hospital Indemnity Coverage

Hospital Indemnity Insurance provides additional financial support when you need it most. This benefit will provide you with a cash reimbursement in the event you are admitted to the hospital as a result of a covered illness and/or injury. Since this benefit is paid directly to you, you are eligible to use the funds towards expenses that are not covered by your health insurance.

Examples of Eligible Expenses

- Deductibles
- Coinsurance
- Cost-of-living expenses
- Copays
- Childcare expenses
- Rehabilitation

Standard Insurance Company
City of Neenah
Group Policy #171844

Group Accident Insurance

Keep your finances on track when an accident happens.

Here's How Accident Insurance Works

1 You have an accident.

Your health insurance covers some costs, after you meet your deductible. But you still may have copays and a lot of out-of-pocket expenses.

2 We send you a check.

The Standard will send a check directly to you — not to your medical providers — upon approval of your claim. You decide how you spend the money.

3 You focus on getting better.

With The Standard helping you handle the unexpected expenses, you get to pay attention to what matters most — your health.

Here's what it does:

- **Pays you directly**, so you can choose how to spend the money.
- **Pays you for what happens**, regardless of your other coverage.
- **Goes with you** if you leave your employer.
- **Provides coverage without answering any medical questions.**
- Gives you the option to **cover your spouse and children**.
- **Pays an additional 25 percent benefit** if your child, 18 or under, is injured playing organized sports.
- **You pay the same premium** for as long as you have your coverage.
- Provides the convenience of having your **premium payments deducted directly from your paycheck**.

This coverage from Standard Insurance Company (The Standard) can help you stress less about unexpected medical bills.

Here's an example of benefits paid for a covered accident:

You're injured during your city league soccer game. An ER visit and scans reveal a concussion, broken leg, torn ACL and meniscus - requiring a 2 day hospital stay and surgery.

Here's what your plan would cover for this example:

Benefits Paid to You	Benefit Amounts
Emergency Room Visit	$150
X-ray	$50
Concussion	$150
Leg Fracture (Surgical)	$2,400
Knee Cartilage Repair	$750
Hospital Admission	$1,000
2 Days Hospital Confinement	$400
Medical Appliance	$100
Physician Follow-Up Appointment	$50
2 Physical Therapy Appointments	$100
TOTAL	**$5,150**

Here's what it would cost you:

Coverage for...	Monthly Premium
You	$9.51
You and your spouse	$15.10
You and your children	$17.96
You, your spouse and your children	$28.19

Accident Insurance Includes 70+ Benefits for Covered Injuries and Treatment

This is only a partial listing of benefits offered. The specific benefit amounts you'd receive vary. Please consult with your human resources representative or plan administrator for more details.

Injury

- Burns
- Dislocations
- Eye Injuries
- Concussion
- Loss of Hearing
- Lacerations
- Fractures
- Coma
- Paralysis

Emergency

- Emergency Dental
- Urgent Care
- Ambulance
- Emergency Room
- X-ray
- Major Diagnostic Exam

Surgery

- Abdominal/Thoracic Surgery
- Outpatient Surgical Facility
- Skin Grafts
- Knee Cartilage/ Ligament/ Tendon Repair
- Ruptured Disk
- Rotator Cuff

Hospitalization

- Hospital Admission
- Hospital Confinement
- CCU Confinement
- CCU Admission

Follow-Up Care

- Chiropractor
- Medical Appliance
- Hearing Device
- Physical Therapy
- Physician Care
- Prosthesis
- Rehab Facility

Value Added Benefits

- Transportation
- Lodging
- Youth Organized Sports Benefit

Additional Benefits

24-hour coverage – Includes coverage for accidents that occur on and off the job.

Accidental Death & Dismemberment — Includes a benefit for an accidental death or covered dismemberment for you or your dependents.

Line of Duty Benefit — Provides an additional benefit for public safety officers who suffer an accidental death or covered dismemberment or impairment while on the job.

Health Maintenance Screening Benefit — Pays a $50 benefit once per calendar year when you or your dependents go to the doctor for a covered wellness screening, which may include a novel infectious disease test (including COVID-19) or a mammogram.

Automobile Accident Benefit — Provides an additional $500 benefit for injuries you or your dependents sustain while traveling in an automobile involved in a covered accident.

Standard Insurance Company
City of Neenah
Group Policy #171844

Group Critical Illness Insurance

Plan for the Costs of a Serious Illness So You Can Focus on Getting Well.

1 You get a critical illness diagnosis

Your health insurance covers many of your treatment costs, but you still have a lot of expenses that your finances aren't ready for.

2 The Standard is there for you

The Standard helps shield your finances by paying benefits directly to you. And you get to decide how you spend that money.

3 Focus on getting better

With The Standard helping cover your out-of-pocket or everyday expenses, you get to concentrate on what's most important to you, getting better.

Here's what it does:

- **Pays you directly**, so you can choose how to spend the money
- **Goes with you** if you leave your employer
- **Provides coverage** without answering any medical questions
- **Covers children** at a 50% of your benefit amount at no additional cost
- Gives you the option to **cover your spouse**

This coverage from Standard Insurance Company (The Standard) helps fill the gap caused by out-of-pocket costs, creating a financial safety net for you and your family.

Here's how it works:

Cancer: Shayna beat cancer, but faced many costs she didn't expect. There were her medical plan's copays for doctor visits and what she owed for chemotherapy after meeting her deductible. She also bought hair prosthetics, paid for travel to specialists, and had alternative treatments. The benefits from Shayna's Critical Illness insurance helped cover the expenses. And, her plan also gave her access to Health Advocate™. Through this service, Shayna received the support of a personal guide who helped her make sense of her diagnosis and treatment options.

You choose your coverage amount. Here's an example of what each benefit could cover:

Example Of Out-Of-Pocket Expenses

Medical plan	$1,400
Lost wages	$5,000
Alternate treatments and diets not covered by medical plan	$4,500
Total Out-Of-Pocket Expenses	**$10,900**

Example Of Benefits

Critical Illness Benefit Option	$5,000	$10,000	$20,000
Total Out-Of-Pocket Expenses	**$10,900**	**$10,900**	**$10,900**
Remaining Out-Of-Pocket Expenses	$5,900	$900	$0
Remaining Benefit For Other Expenses	**$0**	**$0**	**$9,100**

These are the benefit options you may elect:

Coverage for...	Coverage Amount...
You	$5,000-$30,000 in increments of $5,000
Your spouse	$5,000-$15,000 in increments of $5,000, as long as it's not more than your coverage amount
Your children	Automatically covered at 50% of your coverage amount

See the Important Details section for more information, including requirements, exclusions and definitions.

Affordable Group Rates

Because you'll be buying this insurance through City of Neenah, you'll have access to affordable group rates. You'll also have the convenience of having your premium deducted directly from your paycheck.

The monthly premiums you would pay for Critical Illness insurance benefits are below.

Employee Monthly Attained Age Premiums						
Coverage Amount	Employee Age					
	18-29	30-39	40-49	50-59	60-69	70+
$5,000	$1.90	$2.90	$5.85	$12.10	$22.30	$57.10
$10,000	$3.80	$5.80	$11.70	$24.20	$44.60	$114.20
$15,000	$5.70	$8.70	$17.55	$36.30	$66.90	$171.30
$20,000	$7.60	$11.60	$23.40	$48.40	$89.20	$228.40
$25,000	$9.50	$14.50	$29.25	$60.50	$111.50	$285.50
$30,000	$11.40	$17.40	$35.10	$72.60	$133.80	$342.60

Spouse Monthly Attained Age Premiums						
Coverage Amount	Employee Age					
	18-29	30-39	40-49	50-59	60-69	70+
$5,000	$1.90	$2.90	$5.85	$12.10	$22.30	$57.10
$10,000	$3.80	$5.80	$11.70	$24.20	$44.60	$114.20
$15,000	$5.70	$8.70	$17.55	$36.30	$66.90	$171.30

With Critical Illness insurance, you can:

- **Protect your loved ones.** Cover your spouse up to $15,000, as long as it's not more than your benefit amount. Your kids are automatically covered at 50 percent of the amount elected for yourself for the same critical illnesses that you are. Kids are also covered for 21 additional childhood diseases, including cystic fibrosis, Down syndrome, muscular dystrophy, spina bifida and cerebral palsy.
- **Receive a benefit for taking care of your health.** You and your covered loved ones receive a Health Maintenance Screening benefit of $50 once per calendar year when visiting the doctor for a covered wellness screening, which may include a novel infectious disease test (including COVID-19) or a mammogram — that typically cost you nothing under your medical insurance.
- **Receive additional benefits.** If you are diagnosed with a covered illness again after a treatment-free period of 6 months, you will receive 50 percent of the original benefit amount. If you are diagnosed with a different and subsequent covered illness after the diagnosis of the first critical illness, you will receive an additional Critical Illness insurance benefit.
- **Access a Health Advocate*.** Additional services available through Health Advocate, include access to specialists for a second opinion upon approval of a covered claim.
- **Update your coverage as needed.** As your life circumstances change, increase or decrease your coverage, in accordance with your employer's plan.

Covered Conditions

Receive 100 percent of your coverage amount for:

- Heart attack
- Stroke
- Cancer (cancer that has spread beyond initial tissue)
- End stage renal (kidney) failure
- Major organ failure
- Coma
- Paralysis of two or more limbs
- Loss of sight
- Occupational HIV
- Occupational Hepatitis
- ALS (Lou Gehrig's Disease)
- Advanced Alzheimer's Disease
- Advanced Multiple sclerosis
- Advanced Parkinson's disease
- Benign brain tumor
- Bone marrow transplant
- Loss of hearing
- Loss of speech

Receive 25 percent of your coverage amount for:

- Severe coronary artery disease with recommendation for bypass
- Cancer that has not spread beyond initial tissue, also known as Carcinoma in situ

* Health Advocacy services are provided through an arrangement with Health Advocate, a leading health advocacy and assistance company. Health Advocate is not affiliated with The Standard or any insurance or third-party provider, and does not replace health insurance coverage, provide medical care or recommend treatment.

Payment of benefits is subject to the terms and conditions of the group critical illness policy and insurance certificate. These plan documents are the final arbiter of coverages.

Diagnosis and recommendation must occur after your coverage becomes effective.

Please see your certificate for full medical definitions that guide eligibility for payment, which may differ slightly from commonly used terms.

Standard Insurance Company
City of Neenah
Group Policy #171844

Group Hospital Indemnity Insurance

Keep your finances on track when you're in the hospital.

1 You're admitted to the hospital.

Your health insurance covers many costs of your stay and treatment. But you still have a lot of expenses, including deductibles, copays, and other costs you couldn't predict.

2 We send you a check.

The Standard will send a check directly to you - not to your medical providers - upon approval of your claim. You decide how you spend the money.

3 You focus on recovering.

With The Standard helping you handle the costs of your hospital stay, you get to concentrate on what matters most - your health.

Here's what it does:

- **Pays you directly**, so you can choose how to spend the money
- **Goes with you** if you leave your employer
- **Provides coverage** without answering any medical questions
- Gives you the option to **cover your spouse and children**
- **Protects your HSA Account**
- Provides the convenience of having your **premium payments deducted directly from your paycheck**

This coverage from Standard Insurance Company (The Standard) can help protect your finances and provides you peace of mind.

Here's how it works:

Ruptured Ulcer: Kim is out of town on a business trip when she experiences abdominal pain and a racing heartbeat. Diagnosis: ruptured gastric ulcer. She is rushed to the hospital, admitted and taken into surgery. She ends up being hospitalized for 10 days, three of which are in a critical care unit. Kim's spouse leaves their two kids with their daycare provider and flies to be at her side. The family now faces additional costs for medical bills, travel, and childcare amounting to $3,850.

Here's what your plan would cover for this example:

Benefits Paid to You	Benefit Amount
Hospital admission	$500
Hospital confinement (10 days)	$1,000
Critical care unit confinement (3 days)	$150
Total paid to you	**$1,650**

Here's what it would cost you:

Coverage for...	Monthly Premium
You	$9.01
You and your spouse	$15.50
You and your children	$12.99
You, your spouse and your children	$22.92

Group Hospital Indemnity Insurance

Here's what it covers:

Benefits Paid to You	Benefit Amount
Hospital Admission[1]	$500 Maximum 1 per calendar year
Daily Hospital Confinement [1]	$100 per day Maximum 30 days per stay
Daily Critical Care Unit Confinement[1,2]	$50 per day Maximum 30 days per stay

1 Defined as a stay for at least 20 consecutive hours in a hospital setting.

2 Payable in addition to the Hospital Admission and Daily Hospital Confinement benefit you may be eligible to receive.

Additional Benefits

Waiver of Premium – Premium waived if you are confined to a hospital for more than 30 days.

Health Maintenance Screening Benefit – Pays a $50 benefit once per calendar year when you or your dependents go to the doctor for a covered wellness screening, which may include a novel infectious disease test (including COVID-19) or a mammogram.

Protect your HSA Account – Hospital Indemnity insurance provides financial protection while you are building your HSA assets. Contact your employer to determine if this Hospital Indemnity plan impacts the taxability of your contributions to an HSA. It's protection that's also convenient: Your premium payments can be deducted directly from your paycheck.

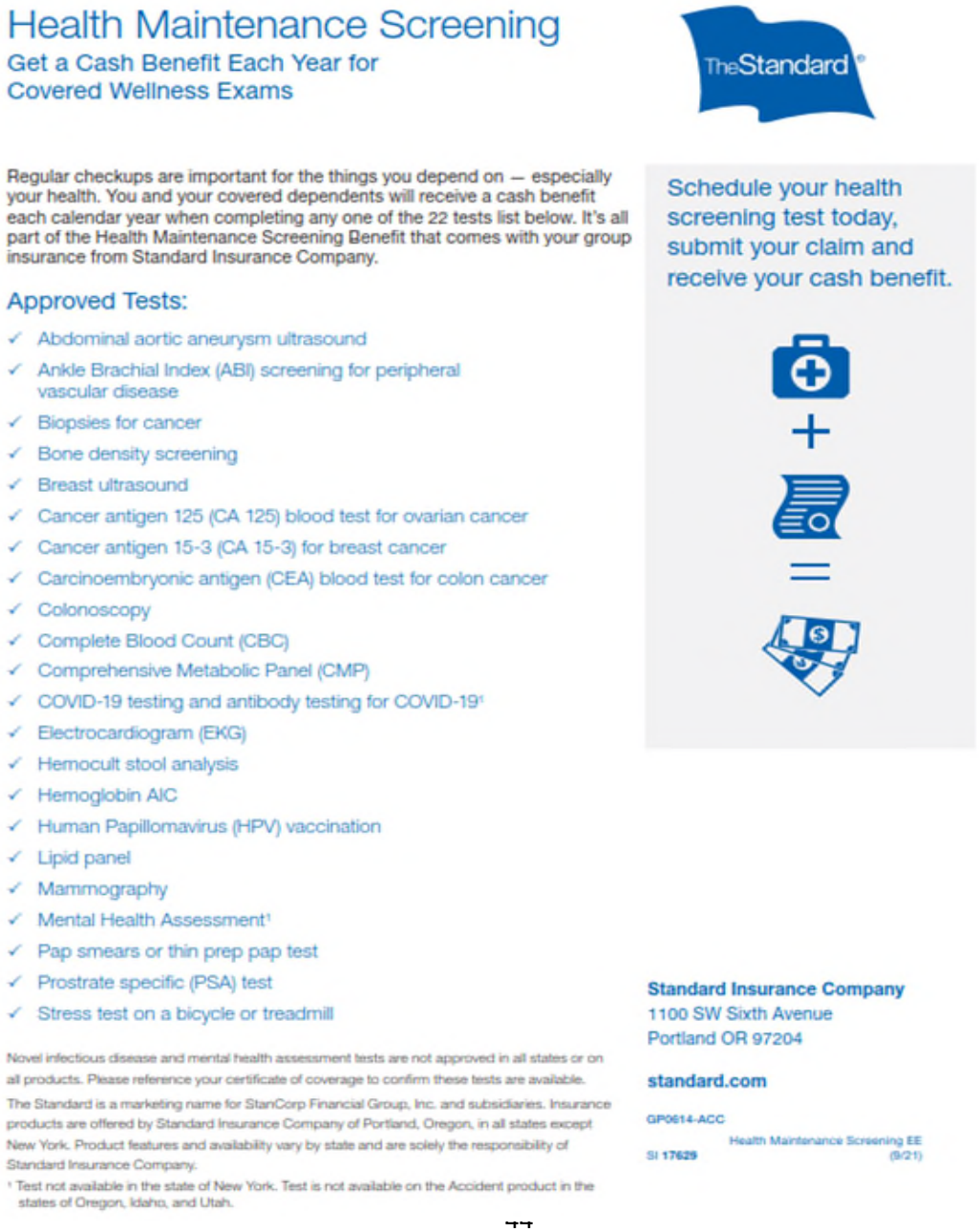
Ancillary Health Maintenance Screening Information:

To claim your annual health maintenance screening benefit, login to The Standard website at: standard.com

Your plan/policy number is CITYOFNEENAH

Once registered, complete the provided instructions to submit your health maintenance claim.

Additional resources may be found on your benefits portal through Bentek.



Health Maintenance Screening

Get a Cash Benefit Each Year for Covered Wellness Exams

TheStandard®

Regular checkups are important for the things you depend on — especially your health. You and your covered dependents will receive a cash benefit each calendar year when completing any one of the 22 tests list below. It's all part of the Health Maintenance Screening Benefit that comes with your group insurance from Standard Insurance Company.

Approved Tests:

- ✓ Abdominal aortic aneurysm ultrasound
- ✓ Ankle Brachial Index (ABI) screening for peripheral vascular disease
- ✓ Biopsies for cancer
- ✓ Bone density screening
- ✓ Breast ultrasound
- ✓ Cancer antigen 125 (CA 125) blood test for ovarian cancer
- ✓ Cancer antigen 15-3 (CA 15-3) for breast cancer
- ✓ Carcinoembryonic antigen (CEA) blood test for colon cancer
- ✓ Colonoscopy
- ✓ Complete Blood Count (CBC)
- ✓ Comprehensive Metabolic Panel (CMP)
- ✓ COVID-19 testing and antibody testing for COVID-19[1]
- ✓ Electrocardiogram (EKG)
- ✓ Hemocult stool analysis
- ✓ Hemoglobin AIC
- ✓ Human Papillomavirus (HPV) vaccination
- ✓ Lipid panel
- ✓ Mammography
- ✓ Mental Health Assessment[1]
- ✓ Pap smears or thin prep pap test
- ✓ Prostrate specific (PSA) test
- ✓ Stress test on a bicycle or treadmill

Schedule your health screening test today, submit your claim and receive your cash benefit.

Novel infectious disease and mental health assessment tests are not approved in all states or on all products. Please reference your certificate of coverage to confirm these tests are available.

The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Oregon, in all states except New York. Product features and availability vary by state and are solely the responsibility of Standard Insurance Company.

[1] Test not available in the state of New York. Test is not available on the Accident product in the states of Oregon, Idaho, and Utah.

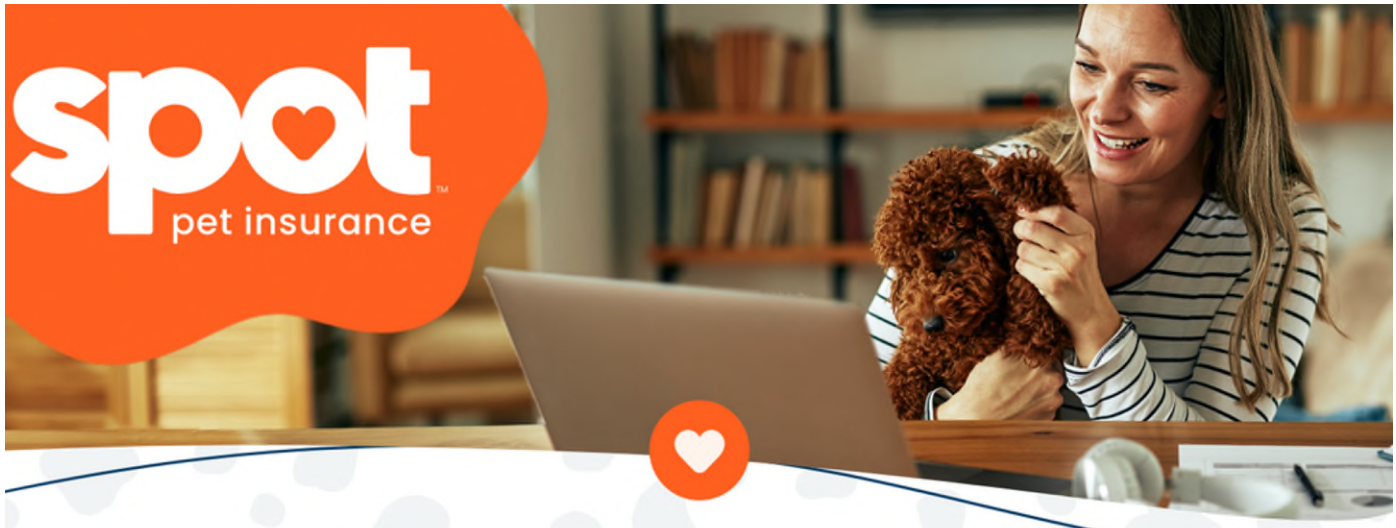
Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

standard.com

GP0614-ACC

SI 17629 Health Maintenance Screening EE (9/21)

spot pet insurance



Your New Pet Insurance Benefit

Protect Your Pet & Your Wallet

Cap off your benefits with pet insurance from Spot and get reimbursed on covered vet bills for accidents, illnesses, & more.

- Up to 90% Cash Back
- Preventative Care Add-Ons
- 24/7 Pet Telehealth Line

How Spot Pet Insurance Works

Visit any licensed vet or specialist.

Submit your claim online.

Get reimbursed fast & easily.

Special Offer Just for You: Up to 20% Off

Neenah WISCONSIN

Get Your Quote Today: spotpet.link/neenahwi

When calling, use priority code: EB_NEENAHWI | 888.343.2340

Mental Health Resources

Employee Assistance Program (EAP)

Life doesn't always go as planned. From time to time, we may face personal, financial, legal, or other issues which can negatively affect our mental well-being. In these situations, our stress often transfers to the ones who matter most, our family members. That's why the City of Neenah has partnered with Ascension to provide short-term counseling and support services.

The City of Neenah offers this benefit to you and your immediate family members at no cost. To access services, simply call Ascension at 800-540-3758. A phone call allows you to establish an appointment with one of their counselors. Our EAP benefit offers up to 8 sessions per issue. In most situations additional services won't be needed. If other services are necessary, Ascension will facilitate a referral and those services will be paid according to your health plan coverage.

It should be noted that Ascension makes every effort to protect your privacy and ensure that your EAP service is completely confidential. The City of Neenah does not know who utilizes these services and we encourage you and your family to take full advantage of the benefits of our EAP.

Common Concerns

- Depression
- Divorce
- Legal issues
- Financial pressure
- Caring for aging parents
- Seeking child care
- Workplace stress
- Relationship issues

Ascension Employee Assistance Program (EAP)

Your company prioritizes employee mental and emotional health by offering a free and confidential EAP benefit to both employee's and their household members. Ascension EAP provides support and resources to help navigate any life challenges you might encounter.

Your EAP benefit offers short-term counseling, up to 8 sessions per issue, at no cost to you or your family members. EAP can also provide resources and referrals. To access this benefit you can call 800-540-3758, email eap@ascension.org or visit their website www.ascensioneap.org.
Intake counselors are available to help schedule or answer any questions you might have.

Common concerns include:

- Relationship/Family
- Depression/Anxiety
- Workplace
- Parenting
- Conflict resolution
- Financial
- Stress management
- Substance abuse

Don’t struggle alone

Whether you’ve been struggling for a long time, or just want a wellness tune-up, there is no problem too big or too small for EAP

Most people experience personal and familial problems at some point in their life. Some issues we can solve on our own, while others may benefit from professional help. Balancing the important areas in our life, whether emotional, psychological, marital, alcohol and drug, or family related, can be difficult.

Fortunately, help is available.

Your Employee Assistance Program (EAP) can help you find solutions to your concerns. This might involve short term counseling or a referral to counseling, support groups or community programs that address your needs. Using EAP to deal with a worrisome situation can help prevent it from becoming a major problem. Your EAP provides free problem assessment, short term counseling, referral and follow-up for you and your family. All contacts with the EAP are strictly confidential.

- Family and marital counseling
- Depression, stress or anxiety
- Grief support
- Workplace stress or conflict
- Substance abuse concerns

Services are free and confidential

800-540-3758 | eap@ascension.org | www.AscensionEAP.org

Ascension

Employee Assistance Program (EAP)

Frequently asked questions

What is EAP?

Employee Assistance Program, or EAP, is an accessible and confidential counseling benefit.

Who can use EAP?

Any employee in your organization can use EAP services, as well as any employee's spouse or dependent children. Sometimes people come in individually, and sometimes it is more helpful to come in as a couple or family.

Who will know if I have used EAP?

No one will know if you have used EAP. Your confidentiality is important to us, but not only that, it is the law.

How much does it cost?

EAP is FREE to you and your family. Your organization provides this benefit at no cost to you.

When should I use EAP?

Our counselors can help with all sorts of problems including: family relationships, grief, work conflicts, substance abuse, mental illness, trauma and more. There is no problem too big or too small.

What will happen when I call?

When you call, you will reach the main office where a professional counselor is available to talk Monday through Friday, 8 a.m.-5 p.m. They can either help you set up an appointment or connect you with someone to talk to immediately on the phone. If you are in crisis after hours, the answering service can page a counselor who will call you back shortly. You never have to struggle alone!

Who are the counselors?

All our counselors are licensed to provide counseling in the state in which they practice. Their bios can be found on our website under the link 'About Us' at www.AscensionEAP.org

How much can I use EAP?

EAP is short-term, solution-focused counseling. Many people can resolve their concerns within a few sessions, but if you need something more than short-term counseling can provide, your counselor can make referrals to help you get you connected to the right type of support for your needs.

Ascension

Medicare, Individual Insurance, & Financial Resources

MEDICARE

Rachel Hug
Client Executive
rachel.hug@m3ins.com
414.978.1424

If you or someone close to you is nearing retirement, turning 65, or just looking for general information about Medicare, turn to **Rachel Hug** for insight and guidance around the right coverage, carriers, value, and price.

We do not offer every plan available in your area. Currently we represent 15 organizations which offer 76 products in your area. Please contact Medicare.gov, 1–800–MEDICARE, or your local State Health Insurance Program to get information on all of your options.

Scan to learn more about Rachel

INDIVIDUAL HEALTH

Natalie Damro
Account Executive
natalie.damro@m3ins.com
920.455.7289

There are many reasons you might choose to explore an individual health plan: maybe you're retiring early, preparing for an employment gap, or you could be a 1099 employee. Then, there's the major reason why you may be hesitant - it's a complicated landscape. **Natalie Damro** knows the individual marketplace and can ease some of your worry.

Scan to learn more about Natalie

FINANCIAL SERVICES

Nicholas Natzke
Wealth Advisor
nicholas.natzke@m3ins.com
920.455.7290

Your unique financial history and future aspirations should be the driving force behind your investment strategy. An initial conversation with **Nicholas Natzke** can answer questions about financial topics, services, and basic level competency of investments.

Investment advisory services offered through Global Retirement Partners, LLC (GRP) dba M3 Financial, a registered investment advisor. GRP and M3 Insurance are separate and unaffiliated.

Schedule a meeting with Nicholas

M3 INSURANCE 800.272.2443 | m3ins.com

M3 ELEVATE

M3 FINANCIAL

Life Insurance

The City provides basic life insurance in the amount of one times an employee's annual salary at **no cost** to the employee to all eligible employees (generally all regular full time and part-time employees who are WRS eligible). To receive the free basic coverage, the employee must complete the application within the first 30 days of employment.

Coverage takes effect the first of the month following 30 days from the date of hire, the first day of the month following 30 days from return from an approved leave of absence, or the first day of the month following 30 days from the date of the qualifying family status change event, whichever is applicable.

Employees have the option to elect Supplemental, Additional, and Spouse (Domestic Partner) / Dependent coverage at their own cost. Rates of these coverages are determined by age and salary.

Income Continuation Insurance

The Income Continuation Insurance (ICI) benefit is a voluntary "income replacement" benefit offered by the Department of Employee Trust Funds (ETF) that is payable if an employee becomes disabled. This insurance is available to all employees who are under age 70 and employed in a WRS-covered position. The ICI benefit provides up to 75% of your monthly earnings based on the previous calendar year earnings, up to a maximum of $120,000.

Coverage is effective the first of the month following the employee's hire day, consistent with the City's medical plan.

This benefit is currently under a premium Holiday, and as such there is **no cost** to you, the employee. Should this change, the City will notify you of any changes and give you the opportunity to opt out of the program before any premiums are applied.

Employees utilizing this benefit should contact Human Resources for policy provisions as it relates to your accruals.

Retirement Plan (WRS)

All eligible employees are automatically enrolled into the Wisconsin Retirement System (WRS). The City of Neenah pays the employer portion, and each eligible employee is responsible for the employee portion as defined by the state.

Employee WRS Contribution Rates

2026 Rates	General, Executive, and Elected Officials	Protective Occupation with Socials Security	Protective Occupation Without Social Security
Employee Contribution	7.2%	7.2%	7.2%
Employer Contribution	7.2%	14.7%	18.5%
Total	14.4%	21.9%	25.7%

Currently all WRS eligible employees who began employment on or after July 1, 2011, must have five years of WRS creditable service to be vested. If you are not vested, you may only receive a separation benefit.

Every year, WRS conducts presentations throughout the state explaining WRS benefits. Human Resources will communicate dates and locations of presentations. Employees and spouses are encouraged to attend these free sessions.

Retirement Plan Options for Employees:

City of Neenah 457(b) Deferred Compensation Plan & Roth IRA
(MissionSquare Retirement)

Plan Introduction:	The City's Deferred Compensation Program and Roth IRA are optional, supplemental retirement savings plans for all working City employees. The Plans allow you to set up your own account and save money directly from your paycheck for retirement. They offer tax benefits and excellent investment options. The value of your account is based on how much money you put into it and how much your investments grow over time.
Your Contributions: The IRS has not yet released the 2026 contribution limits.	• You may contribute to the 457 Deferred Compensation plan on a pre-tax or Roth after tax basis up to a maximum of $23,500 in 2025. An additional $7,500 in 2025 may be contributed as catch-up contributions by participants age 50 and over. • You may contribute to the Roth IRA after tax plan up to a maximum of $7,000 in 2025. An additional $1,000 in 2025 may be contributed as catch-up contributions by participants age 50 and over.
Rolling Money In:	Generally, retirement plan assets with a prior employer can be consolidated into the City of Neenah 457(b) Deferred Comp Plan. To get started, contact Kevin Linsmeier, MissionSquare Retirement Specialist, at KLinsmeier@missionsq.org or (202) 759-7147.
Eligibility Requirements:	Employees have immediate enrollment and immediate entry date for deferrals.
Initial Enrollment Instructions for the 457(b) Deferred Compensation Plan:	First, Enroll online at https://www.msqplanservices.org/myplan/302048. Click on "Enroll In My Plan" and enter your SSN and personal information to register. Next, contact Kevin Linsmeier, MissionSquare Retirement Specialist, at KLinsmeier@missionsq.org or (202) 759-7147 and complete the appropriate attached form with his assistance. Use the attached form labeled "CITY OF NEENAH 457 Deferred Compensation Plan 302048" in the Plan Sponsor Name Section. Then submit the completed form to your HR Department.
Initial Enrollment Instructions for the Roth IRA:	First, Enroll online at https://www.msqplanservices.org/myplan/705580. Click on "Enroll In My Plan" and enter your SSN and personal information to register. Next, contact Kevin Linsmeier, MissionSquare Retirement Specialist, at KLinsmeier@missionsq.org or (202) 759-7147 and complete the attached form with his assistance. Use the form labeled "Payroll Deduct Roth IRA Contribution Form" at the top. Then submit the completed form to your HR Department.
Investment & Contribution Changes:	Transfers between investment options, salary deferral amount adjustments and beneficiary changes can be made on the MissionSquare website (see websites above for your appropriate Plan option) at or by calling 1.800.669.7400.
General Financial Education:	Visit M3's library of financial education videos on topics including identity theft, estate planning, Medicare, investing basics, and more at https://m3financialonlineeducation.videoshowcase.net/ or scan the QR code for direct access.
Financial Planning & Investment Advice:	M3 Financial offers financial planning and investment advice to all employees. To contact M3 Financial or schedule a consultation, email M3 at AskM3Financial@m3fi.com or by phone 608-288-2897.

*Informational only and not intended to replace the legal documents related to the Plan which supersede any of the above.

1872 Mid Valley Drive | De Pere, WI 54115

REQUIRED FEDERAL NOTICES

Table of Contents

HIPAA 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 towards 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).

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.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact one of the following:

- Christina Kleinheinz
  Human Resources Specialist
  ckleinheinz@neenahwi.gov
  920-886-6102
- Amy Fairchild
  Director of Human Resources and Safety
  afairchild@neenahwi.gov
  920-886-6103
- Or email: humanresources@neenahwi.gov

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Effective Date of Notice: 10/22/2025

Who will follow this notice:

This notice describes the health information practices of UMR, Delta, CarePlus (the "Plan") and that of any third party that receives medical information from or for us to assist us in providing your medical, dental, and vision benefits.

Our pledge to you:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you.

This notice is required by the Standards for Privacy of Individually Identifiable Health Information regulations (the "Rule"). This notice will tell you about the ways in which we may use or disclose medical information about you. It also describes our obligations and your rights regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

HOW THE PLAN MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

The following categories describe different ways that we use and disclose medical information, as permitted by law. The Plan, its business associates, and their agents/subcontractors, if any, will use or disclose medical information to carry out treatment, payment and health care operations or other purposes permitted or required by law.

In addition, the Plan may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. The Plan will disclose your medical information to City of Neenah ("Plan Sponsor") for purposes related to treatment, payment and health care operations. The plan sponsor has amended its plan documents to protect your medical information as required by the Rule.

Treatment means the provision, coordination, or management of health care by one or more health care providers, or a health care provider and a third party.

Payment means activities undertaken by a health plan to determine coverage responsibilities and payment obligations for the provision of health care, or activities undertaken by a health care provider, or a health plan to obtain or provide reimbursement for health care.

For example, the Plan may disclose to your provider that you are eligible for benefits.

Health Care Operations means activities directly related to the provision of health care or the processing of health information. This includes internal quality oversight review, credentialing and health care provider evaluation, underwriting, insurance rating and other activities related to creation, renewal or replacement of a contract of health insurance or health benefits.

For example, the Plan may use medical information about you to project future benefit costs.

The Plan will disclose medical information about you when required by federal, state or local law.

The Plan may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

The Plan may disclose medial information if you are a member of the armed forces and this is required by military command authorities.

HIPAA NOTICE OF PRIVACY PRACTICES (continued)

The Plan may disclose medical information about you for workers' compensation or similar programs.

The Plan may disclose medical information about you for public health activities. These activities may include the following:

- to prevent or control disease, injury or disability;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

The Plan may disclose medical information to a health oversight agency for activities authorized by law.

The Plan may disclose medical information about you if you are involved in a lawsuit or a dispute and we are responding to a court or administrative order. Also, the Plan may disclose medical information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

The Plan may disclose medical information about you if asked to do so by law enforcement official, such as in response to a court order, subpoena, warrant, summons or similar process;

The Plan may disclose medical information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure to funeral directors, as necessary to carry out their duties, is permitted.

The Plan may not disclose psychotherapy notes (under most circumstances), may not disclose protected health information for marketing purposes, and may not make disclosures that constitute a sale of protected health information unless authorized by the individual. Other disclosures not mentioned in this notice also require authorization from the individual.

The Plan may not disclose protected health information that is genetic information under the Genetic Information Nondiscrimination Act ("GINA") for underwriting purposes.

YOUR RIGHTS

You have the following rights regarding medical information the Plan maintains about you:

You have the right to request an inspection and a copy of your medical information contained in a "designated record set," for as long as the Plan maintains your medical information in the designated record set.

"Designated record set," means a group of records maintained by or for a health plan that is enrollment, payment, claims adjudication and care or medical management record systems maintained by or for a health plan; or used in whole or in part by or for the health plan to make decisions about individuals. Information used for quality control or for health care operations and not used to make decisions about individuals is not in the designated record set.

The Plan has the right to charge a reasonable, cost-based fee for providing a copy of your medical information or summary or explanation of your medical information.

The Plan has the right to 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.

If you feel the medical information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. You have a right to request an amendment for as long as the information is kept by the Plan.

To request an amendment, your request must be in writing and should be addressed to the following individual: Director of Human Resources at humanresources@neenahwi.gov. All requests for amendment of your medical information must include a reason to support the requested amendment.

HIPAA NOTICE OF PRIVACY PRACTICES (continued)

The Plan 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, the Plan may deny your request if you ask to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by the Plan, 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.

You have the right to request an "accounting of disclosures," where such disclosure was made for any purpose other than treatment, payment or health care operations. Additionally, no accounting of disclosures will be made for the following reasons:

- if the disclosure was made to the individual about his or her own medical information;
- if the disclosure was made pursuant to an authorization;
- if the disclosure was made to certain person involved in your care or payment for your care;
- if the disclosure was made prior to the compliance date of April 13, 2004.

To request an accounting of disclosures, address your request to the following individual: Director of Human Resources at humanresources@neenahwi.gov

If you request more than one accounting in a 12-month period, the Plan can charge a reasonable, cost-based fee for each subsequent accounting, unless you withdraw or modify the request for a subsequent accounting to avoid or reduce the fee.

You have the right to request a restriction or limitation on the medical information the Plan uses or discloses about you for treatment, payment or health care operations. You have the right to request a limit on the medical information the Plan discloses about you to someone who is involved in your care or payment for your care, such as friends or family members.

The Plan is not required to agree with your request.

You have the right to restrict certain disclosures of protected health information to a health plan where you pay out of pocket in full for the health care item or service.

To request restrictions, you must make your request in writing to the following individual: Director of Human Resources at humanresources@neenahwi.gov. The request must include (a) what information you want to limit, (b) whether you want to limit the Plan's use, disclosure or both, and (c) to whom you want the limits to apply.

You have the right to request to receive communications of your medical information from the Plan by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information could endanger you. The Plan will accommodate all such reasonable requests.

You will be required to request confidential communications of your medical information in writing. The request should be addressed to the following individual: Director of Human Resources at humanresources@neenahwi.gov.

You have the right to a paper copy of this notice. You may ask the Plan to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You may obtain a copy of this notice on the City's intrant, otherwise known as SharePoint, under the Employee Benefits page.

To obtain a paper copy of this notice, contact the following individual: Director of Human Resources at humanresources@neenahwi.gov.

You have the right to be notified following a breach of unsecured protected health information.

HIPAA NOTICE OF PRIVACY PRACTICES (continued)

If you believe your privacy rights have been violated, you may complain to the Plan. Any complaint must be in writing and addressed to the following individual: Director of Human Resources at humanresources@neenahwi.gov.

You may also file a complaint with the Secretary of Health and Human Services.

The Plan will not retaliate against you for filing a complaint. The Plan will only release the minimum amount of PHI necessary to complete the required task or request.

Other uses or disclosures of your medical information not covered by this notice or the laws that apply will be made only with your written authorization, subject to your right to revoke such authorization. You may revoke the authorization at any time, providing the revocation is done in writing. You understand that the Plan is unable to take back any disclosures already made with your permission.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) ENROLLMENT NOTICE

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. Please see your Summary of Benefits and Coverage (SBC) for deductible and coinsurance information.

If you would like more information on WHCRA benefits, call your Plan Administrator 920-886-6102

WELLNESS PROGRAM DISCLOSURE

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 920.886.6102 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

MEDICARE PART D: CREDITABLE COVERAGE NOTICE

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

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

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

2. City of Neenah has determined that the prescription drug coverage offered by UMR 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.

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

MEDICARE PART D: CREDITABLE COVERAGE NOTICE (continued)

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current City of Neenah coverage will be affected. *See* pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage) which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current City of Neenah coverage, be aware that you and your dependents may be able to get this coverage back if you experience a qualifying event or at the next open enrollment period.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

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

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

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE…

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

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

MEDICARE PART D: CREDITABLE COVERAGE NOTICE (continued)

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: 01/01/2026	
Name of Entity/Sender:	City of Neenah
Contact--Position/Office:	Amy Fairchild / Director of Human Resources Christina Kleinheinz/ HR and Safety Assistant
Address:	211 Walnut Street Neenah, WI 54956
Phone Number:	920-886-6102

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

MARKETPLACE COVERAGE NOTICE

GENERAL INFORMATION

When key parts of the health care law took effect, you were eligible for a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you look at options for you and your family, this notice provides some basic information about the new Marketplace and the employment based coverage offered to you.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find private 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. Annual open enrollment for private health insurance coverage through the Marketplace runs during the months of November, December, January and February. The specific timeline will be announced each year.

CAN I SAVE MONEY ON MY HEALTH INSURNACE 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 are eligible for depends on your household income.

DOES THE HEALTH INSURANCE WE OFFER TO YOU AFFECT YOUR ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If we have offered health coverage that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in our 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 self-only coverage under our health plan is more than a certain percentage of your household income for the year, or if our health plan does not meet the "minimum value"[1] standard set by the Affordable Care Act, you may be eligible for a tax credit. Please visit healthcare.gov for the annual affordability percentage or contact the employer identified on the following page of this notice.

Note: If you purchase a health plan through the Marketplace instead of accepting our health plan coverage, then you may lose our contribution (if any) to your coverage under our health plan. Also, our contribution – as well as your employee contribution – 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 ABOUT THE MARKETPLACE?

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the marketplace and its cost. You can 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..

MARKETPLACE COVERAGE NOTICE (continued)

INFORMATION ABOUT THE HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

If you complete an application for coverage through the Marketplace, you will be asked for information about our health plan. The information below will help you complete an application for coverage in the Marketplace.

Employer Name: City of Neenah
Employer Identification Number (EIN): 39-6005543
Employer Address: 211 Walnut St, Neenah, WI 54956
Employer Phone Number: 920-886-6102
Who can we contact about employee health coverage at this job? Human Resources Director, Amy Fairchild or Human Resources Specialist, Christina Kleinheinz

- You may also be asked whether or not you are currently eligible for our health plan or whether you will become eligible within the next three months. In addition, if you are or will become eligible, you may be required to list the names of your dependents that are eligible for coverage under our health plan.

- If you would like information about the eligibility requirements for our health plan, please read the eligibility provisions described in the Summary Plan Description for our health plan. You can obtain a copy of the Summary Plan Description by contacting your Employer at the phone and/or email listed above.

- If you are eligible for coverage under our health plan, you may be required to check a box indicating whether or not our health plan meets the minimum value standard. Our health plan coverage meets the minimum value standard.

- If you are eligible for coverage under our health plan, you may be asked to provide the amount of premiums you must pay for self-only coverage under the lowest-cost health plan that meets the minimum value standard. If you had the opportunity to receive a premium discount for any tobacco cessation program, you must enter the premium you would pay if you received the maximum discount possible for a tobacco cessation program.

- If you would like information about the premiums for self-only coverage under our lowest-cost health plan, please contact your Employer at the phone and/or email listed above.

- You may also be asked whether or not we will be making certain changes to our health plan coverage for the new plan year. As usual, we will notify you about changes to our health plan coverage after we approve any such changes and inform employees about those changes at the appropriate time. If you are not sure how to answer this question on your Marketplace application, please contact the Marketplace.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since March 17, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

U.S. Department of Health and Human Services
Employee Benefits Security Administration
Centers for Medicare & Medicaid Services

www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

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)