The City of Rock Island Health & Welfare Plan

Notices & Disclosures

for the 2026 Plan Year

Notice of HIPAA Special Enrollment Rights

If you chose to decline enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

You may also be able to enroll in this plan if coverage is lost under a Medicaid plan or CHIP, or due to a determination of eligibility for a premium assistance subsidy under Medicaid or CHIP. In these events *you must request enrollment within 60 days of the date of a determination of eligibility* for premium assistance or the date the Medicaid or CHIP coverage ends.

Additionally, 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.

Please note that in such cases enrollment is not automatic, and therefore following the enrollment process in its entirety is required, even if it does not change your election tier. So for example, you must formally enroll your newborn child onto the plan within 30 days of the date of birth *even if you already have family coverage and your premiums would not change as a result*. Failing to enroll a dependent would result in that dependent not having coverage even though the coverage for the rest of the family would continue.

Finally, please be advised that this plan reserves the right to require a written reason for declining the offer of coverage. When an enrollment/waiver form is provided for this purpose, a signed and dated letter waiving the coverage and specifying the specific reason for declining the coverage may be accepted by the Plan Administrators.

To request special enrollment or obtain more information, contact Angie Rasmussen at 309-732-2058 or rasmussen.angela@rigov.org.

NOTICE: If you or your dependents have Medicare or will become eligible for Medicare in the next 12 months, please see the important notices beginning on Page 8-9 for important information!

All questions should be directed to:

Angie Rasmussen
309-732-2058
rasmussen.angela@rigov.org

Privacy Policy Notice of Availability

Our self-funded health plan, self-funded dental plan, and Flexible Spending Arrangement (FSA) together maintain a *HIPAA Notice of Privacy Practices* (NPP) that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Angie Rasmussen at 309-732-2058 . It is also available for download at https://flimp.live/CityofRockIslandBenefitShowcase.

Newborns' and Mothers' Health Protection Act Notice

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

Note that more generous lengths of stay may apply under certain state laws, when applicable. In such cases, please refer to plan documents for a description of these richer guidelines.

Women's Health and Cancer Rights Act Notice

If you are going to have (or have had) a mastectomy, you may be entitled to health care 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.

Any benefits payable will be subject to the same deductibles, coinsurance and other provisions applicable to other surgical and medical benefits provided under the plan. Please see your Summary of Benefits and Coverage (SBC) or other plan materials for your medical and surgical deductible and coinsurance information.

To request more information on WHCRA benefits, please contact Angie Rasmussen at 309-732-2058 or rasmussen.angela@rigov.org.

General Notice of COBRA Continuation Coverage Rights

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains Public Sector COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What is COBRA continuation coverage?

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

qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is

only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

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

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

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

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

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

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

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

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights can be directed to Angie Rasmussen at 309-732-2058 or rasmussen.angela@rigov.org. For more information about your rights under the Public Health Services Act, including Public Sector COBRA, and other laws affecting group health plans not subject to ERISA due to a governmental plan exemption, contact the Centers for Consumer Information & Insurance Oversight (CCIIO), available at www.cms.gov/cciio/.

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

Keep your Plan informed of address changes

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

Termination of Coverage for Cause

Please be advised that our Plan reserves the right to terminate coverage for cause, when applicable and as permitted by the Plan's rules and/or administrative guidelines.

Presumption of COBRA and USERRA Concurrent Election Disclosure

Please note that any continuation rights under COBRA and the Uniformed Services Employment and Reemployment Rights Act (USERRA), when applicable, are similar but not identical. When both are available, the election for continuation coverage that you, the employee, make pursuant to COBRA will also be considered your election under USERRA for you and your covered dependents. Thus, USERRA will apply with respect to the COBRA continuation coverage elected by you and any COBRA continuation coverage elected by your covered dependents. Continuation coverage under both statutes will run concurrently (at the same time), so that, for example, when your (or your covered dependent's) first 18 months of concurrent COBRA and USERRA continuation coverage ends, you (or your covered dependent) will have up to an additional six months of continuation coverage under USERRA.

For periods of time in which you (or your covered dependents) have continuation coverage pursuant to both COBRA and USERRA, the law that provides the greater benefit will apply. The administrative policies and procedures described in our COBRA Election Notice (for example, the procedures for how to elect COBRA coverage and for paying premiums for COBRA coverage) also apply to USERRA coverage, unless compliance with the COBRA procedures is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

If you have continuation rights under both laws, instead of making the combined COBRA and USERRA election described above you may make

an election under only COBRA or, alternatively, you may make an election under only USERRA. For information about how to make a USERRA-only or COBRA-only election please contact Angie Rasmussen at 309-732-2058 or rasmussen.angela@rigov.org.

Employee Rights Under the Family and Medical Leave Act (FMLA)

Leave Entitlements

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Protections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

**Special "hours of service" requirements apply to airline flight crew employees.*

Requesting Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint, call (866) 4-USWAGE (866-487-9243; TTY 877-889-5627) or go to www.dol.gov/whd.

YOUR RIGHTS UNDER USERRA

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- you ensure that your employer receives advance written or verbal notice of your service;
- you have five years or less of cumulative service in the uniformed services while with that particular employer;
- you return to work or apply for reemployment in a timely manner after conclusion of service; and
- you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

Right to be Free from Discrimination and Retaliation

If you:

- are a past or present member of the uniformed service;
- have applied for membership in the uniformed service; or
- are obligated to serve in the uniformed service;

then an employer may not deny you:

- initial employment;
- reemployment;
- retention in employment;
- promotion; or
- any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

Enforcement

- The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its website at http://www.dol.gov/vets. An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm.
- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed at http://www.dol.gov/vets/programs/userra/poster/htm. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

Taxable Fringe Benefit Reminder for Non-Tax Dependents

Although employers can generally exclude certain fringe benefits from an employee's taxable income, per IRS rules this tax-favored treatment applies only to benefits for employees, their legal spouses, Code §105b tax dependents, and children under 27 at the end of the tax year.

If and when benefits such as health, dental, and vision are provided to individuals who are not tax dependents, **the Fair Market Value of such benefits will be reported as taxable income to the employee** or other recipient in accordance with Federal and State Law, as applicable. **It is our administrative practice to assume these individuals are not tax dependents unless the employee informs us otherwise, in writing, and provides us with any requested evidence or attestation as our administrative guidelines require at the time**.

Finally, be advised that individuals who are not Code §105(b) tax dependents are not eligible for reimbursement using funds from an HSA trust (bank account), even if eligible for reimbursement by the underlying High Deductible Health Plan. Please refer to plan materials for details on eligible individuals for each respective benefit program.

This notice applies to our $250 P020939 only!

NOTE: THE PRIMARY INSURED IS RESPONSIBLE FOR PROVIDING THIS NOTICE TO ALL MEDICARE ELIGIBLE FAMILY MEMBERS (or those about to become Medicare Eligible)!

Notice of Creditable Coverage for the 2026 Plan Year

We have determined that the prescription drug coverage provided under the City of Rock Island Health & Welfare Plan's $250 P020939 is expected to pay out, on average, the same or more than what the standard Medicare prescription drug coverage will pay. This is known as "creditable coverage" as defined by the Medicare Modernization Act (MMA).

Why This is Important

When someone first becomes eligible to enroll in a government-sponsored Medicare "Part D" prescription drug plan, enrollment is considered timely if completed by the end of his or her "Initial Enrollment Period" which ends 3 months after the month in which he or she turned age 65.

Unfortunately, if you choose not to enroll in Medicare Part D during your Initial Enrollment Period, *when you finally do enroll* **you may be subject to a late enrollment penalty** added to your monthly Medicare Part D premium. Specifically, the extra cost, if any, increases *based on the number of full, uncovered months* during which you went without either Medicare Part D or else without "creditable" prescription drug coverage from another source (such as ours).

It is important for those eligible for both Medicare and our group health plan to look ahead and weigh the costs and benefits of the various options on a regular, if not annual, basis. Based on individual facts and circumstances some choose to elect Medicare only, some choose to elect coverage under the group health plan only, while some choose to enroll in both coverages. When both are elected, please note that benefits coordinate according to the Medicare Secondary Payer Rules. That is, one plan or the other would *reduce payment* in order to prevent you from being reimbursed the full amount from both sources. Your age, the reason for your Medicare eligibility and other factors determine which plan is primary (pays first, generally without reductions) versus secondary (pays second, generally with reductions).

Eligible individuals can enroll in a Medicare Part D prescription drug plan during Medicare's "Annual Coordinated Election Period" (a.k.a. "Open Enrollment Period") running from Oct. 15 through Dec. 7 of each year, as well during what is known as a "Medicare Special Enrollment Period" (which is triggered by certain qualifying events, including the loss of creditable group prescription drug coverage). **Those who miss these opportunities are generally unable to enroll in a Medicare Part D plan until another enrollment period becomes available**. Finally, please be cautioned that even if you elect our coverage, you could be subject to a payment of higher Part D premiums if you subsequently experience a break in coverage of 63 continuous days or longer before enrolling in the Medicare Part D plan. Carefully coordinating your transition between plans is therefore essential.

If you are unsure as to whether or when you will become eligible for Medicare, or if you have questions about how to get help to pay for it, please call the Social Security Administration at (800) 772-1213 or visit socialsecurity.gov. Specific questions about our prescription drug coverage should be directed to the customer service number on your ID card, if enrolled, or to Angie Rasmussen at 309-732-2058 or rasmussen.angela@rigov.org.

This notice applies to our $3500 HDHP P020939 MIEEA2070 only!

NOTE: THE PRIMARY INSURED IS RESPONSIBLE FOR PROVIDING THIS NOTICE TO ALL MEDICARE ELIGIBLE FAMILY MEMBERS (or those about to become Medicare Eligible)!

Notice of Non-Creditable Coverage for the 2026 Plan Year

We have determined that the prescription drug coverage provided under the City of Rock Island Health & Welfare Plan's $3500 HDHP P020939 MIEEA2070 is expected to pay out, on average, LESS THAN what the standard Medicare prescription drug coverage will pay. This is known as "non-creditable coverage" as defined by the Medicare Modernization Act (MMA).

Why This is Important

When someone first becomes eligible to enroll in a government-sponsored Medicare "Part D" prescription drug plan, enrollment is considered timely if completed by the end of his or her "Initial Enrollment Period" which ends 3 months after the month in which he or she turned age 65.

Unfortunately, if you choose not to enroll in Medicare Part D during your Initial Enrollment Period, when you finally do enroll you may be subject to a late enrollment penalty added to your monthly Medicare Part D premium. Specifically, the extra cost, if any, increases based on the number of full, uncovered months during which you went without either Medicare Part D or else without "creditable" prescription drug coverage (obtained through another source).

It is important for those eligible for both Medicare and our group health plan to look ahead and weigh the costs and benefits of the various options on a regular, if not annual, basis. Based on individual facts and circumstances some choose to elect Medicare only, some choose to elect coverage under the group health plan only, while some choose to enroll in both coverages. When both are elected, please note that benefits coordinate according to the Medicare Secondary Payer Rules. That is, one plan or the other would reduce payment in order to prevent you from being reimbursed the full amount from both sources. Your age, the reason for your Medicare eligibility and other factors determine which plan is primary (pays first, generally without reductions) versus secondary (pays second, generally with reductions).

Eligible individuals can enroll in a Medicare Part D prescription drug plan during Medicare's "Annual Coordinated Election Period" (a.k.a. "Open Enrollment Period") running from Oct. 15 through Dec. 7 of each year, as well during what is known as a "Medicare Special Enrollment Period" (which is triggered by certain qualifying events, including the loss of creditable group prescription drug coverage). Those who miss these opportunities are generally unable to enroll in a Medicare Part D plan until another enrollment period becomes available. Finally, please be cautioned that even if you elect our coverage, you could be subject to a payment of higher Part D premiums if you subsequently experience a break in coverage of 63 continuous days or longer before enrolling in the Medicare Part D plan. Carefully coordinating your transition between plans is therefore essential.

If you are unsure as to whether or when you will become eligible for Medicare, or if you have questions about how to get help to pay for it, please call the Social Security Administration at (800) 772-1213 or visit socialsecurity.gov. Specific questions about our prescription drug coverage should be directed to the customer service number on your ID card, if enrolled, or to Angie Rasmussen at 309-732-2058 or rasmussen.angela@rigov.org.

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

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance from Medicaid in paying for your employer health plan premiums. The following list of states is current as of Jan. 31, 2026. Contact your State for more information on eligibility –

ALABAMA | Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA | Medicaid
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
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA | Medicaid
Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO | Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/ TTY 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991, TTY: 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA | Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA | Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization- act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA | Medicaid
Website: https://www.in.gov/medicaid/ or http://www.in.gov/fssa/dfr/
Family & Social Services Admin Phone: 1-800-403-0864, Member Services Phone: 1-800-457-4584

IOWA | Medicaid & CHIP (Hawki)
Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid Phone: 1-800-338-8366
Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
HIPP Phone: 1-888-346-9562

KANSAS | Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPAA Phone: 1-800-967-4660

KENTUCKY | Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718

KENTUCKY | Medicaid (continued)
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA | Medicaid & LaHIPP
Louisiana Medicaid Website: www.ldh.la.gov/healthy-louisianna
Medicaid Hotline: 888-342-6207
Medicaid email: healthy@la.gov
Louisiana Health Insurance Premium Program (LaHIPP) website: www.ldh.la.gov/lahipp, LaHIPP Phone: 1-877-697-6703, LaHIPP Email: La.HIPP@la.gov, LaHIPP Fax: 888-716-9787, LaHIPP Address: 100 Crescent Centre Pkwy #1000, Tucker, GA 30084

MAINE | Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003, TTY: 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740 TTY: 711

MASSACHUSETTS | Medicaid & CHIP
Website: www.mass.gov/masshealth/pa
Phone: 1-800-862-4840, TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA | Medicaid
Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

MISSOURI | Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA | Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA | Medicaid
Website: http://www.ACCESSNebraska.ne.gov, Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA | Medicaid
Medicaid Website:
https://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE | Medicaid
Website:
https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY | Medicaid & CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 800-356-1561, CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/ index.html
CHIP Phone: 1-800-701-0710 (TTY 711)

NEW YORK | Medicaid
Website:
https://www.health.ny.gov/health_care/medicaid/, Phone: 1-800-541-2831

NORTH CAROLINA | Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA | Medicaid
Website:
https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA | Medicaid & CHIP
Website: http://www.insureoklahoma.org, Phone: 1-888-365-3742

OREGON | Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA | Medicaid & 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:
https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx, CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND | Medicaid & CHIP
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA | Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA | Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS | Medicaid
Website:
https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH | Medicaid & CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website:
https://medicaid.utah.gov/
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/

UTAH | Medicaid & CHIP (continued)
CHIP Website:
http://health.utah.gov/chip

VERMONT | Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program, Phone: 1-800-250-8427

VIRGINIA | Medicaid & CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON | Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA | Medicaid & CHIP
Website: https://dhhr.wv.gov.bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN | Medicaid & CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING | Medicaid
Website:
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since Jan. 31, 2026, or for more information on special enrollment rights, contact either:

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

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

HIPAA Notice of Privacy Practices

for City of Rock Island's

Health, Dental, and FSA Plan Participants

Our self-funded health plan, self-funded dental plan, and Flexible Spending Arrangement (FSA) together maintain HIPAA Privacy and Security policies and procedures designated to safeguard your privacy. 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.

To exercise your rights or ask specific questions about our privacy practices, please contact Angie Rasmussen at 309-732-2058 or rasmussen.angela@rigov.org.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. All requests for access to your protected health information (and its use and other related information) must be made in writing.

Get a copy of health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days
Request confidential communications	• You can ask us to contact you in a specific way (for example, home, office, or mobile phone) or to send mail to a different address. • We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment or our operations. • We are not required to agree to your request, and we may say "no," for example, if it could affect your care. If we agree to your request, we may still share this information in the event that you need emergency treatment.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If someone has authority to act as your personal representative, such as if someone has your medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775 or visiting **www.hhs.gov/hipaa/filing-a-complaint/index.html**. • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

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

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways:

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	*Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage**. This does not apply to long term care plans.	*Example: We use health information about you to develop better services for you.*
Pay for your health services	• We can use and disclose your health information as we pay for your health services	*Example: We share information about you with your dental plan to coordinate payment for your dental work.*
Administer your plan	• We may disclose your health information to your health plan sponsor for plan administration.	*Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

How else can we use or share your health information? We are allowed or required to share your information in other ways—usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. And in all cases, if we have substance use disorder (SUD) patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, administrative, or legislative investigations or proceedings against you without (1) your consent or (2) a court order and a subpoena. However, be advised that in any case where you consent to the disclosure of your Part 2 records for treatment, payment, or health care operations, the information disclosed may be redisclosed by the recipient and may no longer be protected by Part 2.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Help with public health and safety issues	We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation	• We can share health information about you with organ procurement organizations.

requests, and work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner or funeral director when an individual dies.
Address workers' compensation, law enforcement and other government requests	We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

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

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

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

Marketplace (Exchange) Notice – Your ACA Coverage Options

To assist you as you evaluate options for you and your family, this notice provides some basic information about the ACA Health Insurance Marketplace (the "exchange") and employment based health coverage offered.

What is the Government-run Health Insurance Marketplace (exchange)?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage occurs on an annual basis, and Special enrollment Periods are available throughout the year to those with a qualifying life event such as marriage, divorce, birth or adoption of a child, loss of a job and other events.

Can I save money on my health insurance premiums in the Marketplace?

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

Does employer health coverage affect eligibility for premium savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium and a reduction in plan cost-sharing if your employer a) does not offer coverage to you at all or b) does not offer coverage that meets certain standards. Specifically, if your cost for SELF-ONLY coverage on a plan offered to you by your employer is more than 9.5% of your household income for the year (plus all applicable adjustments for inflation), OR if the coverage your employer provides does not meet the "Minimum Value (MV) Standard" set by the Affordable Care Act, you may be eligible for a tax credit. [1]

Note: There may be some disadvantages if you purchase a health plan through the Marketplace instead of accepting coverage offered by your employer. First, current regulations generally prohibit employers from contributing funds toward non-group health premiums. This means that you will lose any employer premium contributions that would have otherwise been payable. Second, the costs paid toward employer-offered health coverage are generally excluded from income for Federal and State income tax purposes. However, payments for coverage through the Marketplace are made on an AFTER-tax basis.

When can I enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts each Nov. 1 and continues through at least Dec. 15. Certain events may also trigger a midyear Special Enrollment Period, such as when getting married, having a baby or adopting a child, or losing eligibility for other health coverage.

How can I get more information?

For more information about your coverage offered by your employer, please check your coverage materials or contact Angie Rasmussen at 309-732-2058 or rasmussen.angela@rigov.org. The Marketplace or a licensed insurance broker can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov to find more information.

[1] *An employer-sponsored health plan meets the "Minimum Value (MV) 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 and meets other requirements.*

Employer-Specific Information

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

3. Employer name	4. Employer Identification Number
City of Rock Island	36-6006077
5. Employer address	**6. Employer phone number**
1528 Third Avenue	309-732-2058

7. City	8. State	9. Zip code
Rock Island	IL	61201

10. Who can we contact about employee health coverage at this job?	
Angie Rasmussen	
11. Phone number (if different from above)	**12. Email address**
309-732-2058	rasmussen.angela@rigov.org

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

As your employer, we offer a health plan to:

All employees we deem eligible for health coverage under the plan's eligibility rules. Generally speaking, coverage is offered to full-time employees working at least no, but other criteria may apply based on employment class and other facts and circumstances.

With respect to dependents:

All eligible spouses and dependents under the age of 26, as well as others who meet specified criteria (e.g., those who meet disabled dependent definitions). Please contact the individual listed in Box 10 (above) with any questions.

☑ If checked, this coverage meets the minimum value standard and the cost of this coverage is intended to be affordable for most or all full-time employees under one of the §4980H Affordability Safe Harbors.

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

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. You may need to get information from your employer, about their coverage, in order to find out if you qualify for a tax credit to lower your monthly premiums.

Consumer Coverage Disclosure Act (CCDA) Notice

for Residents of the State of Illinois

Employer / Plan Sponsor Name:	City of Rock Island
Employer Situs State:	Illinois
Name of Issuer (or TPA):	Blue Cross Blue Shield of Illinois
Plan Marketing Name:	City of Rock Island Health Plan
Plan Year:	1/1/26 – 12/31/26

The following chart is comprised of the essential health insurance benefits (EHBs) regulated by the State of Illinois, broken down by category. While the columns on the right summarize which are deemed "Covered Benefits" under our group health plan, it is important to refer to the plan and policy documents for other important information including certain limitations, exclusions, and preauthorization protocols that may apply. While we believe the answers below are correct, in all cases the plan and policy documents shall govern in the event of any omissions or discrepancies.

2020-2026 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)

	Illinois Essential Health Benefit (by Category)	Employer Plan "Covered Benefit"?	
		$250 Deductible	**HDHP**
	Ambulatory Patient Services (outpatient care you get without being admitted to a hospital)		
1	Accidental Injury -- Dental	Yes	Yes
2	Allergy Injections and Testing	Yes	Yes
3	Bone anchored hearing aids	Yes	Yes
4	Durable Medical Equipment	Yes	Yes
5	Hospice	Yes	Yes
6	Infertility (Fertility) Treatment	Yes	Yes
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Yes
8	Outpatient Surgery Physician / Surgical Services (Ambulatory Patient Services)	Yes	Yes
9	Private-Duty Nursing	No	No
10	Prosthetics / Orthotics	Yes	Yes
11	Sterilization (vasectomy men)	Yes	Yes
12	Temporomandibular Joint Disorder (TMJ)	Yes	Yes
	Emergency Services		
13	Emergency Room Services (Includes MH/SUD Emergency)	Yes	Yes
14	Emergency Transportation / Ambulance	Yes	Yes
	Hospitalization (like surgery and overnight stays)		
15	Bariatric Surgery (Obesity)	Yes	Yes
16	Breast Reconstruction After Mastectomy	Yes	Yes
17	Reconstructive Surgery	Yes	Yes
18	Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Yes
19	Skilled Nursing Facility	Yes	Yes
20	Transplants - Human Organ Transplants (Including transportation & lodging)	Yes	Yes
	Laboratory Services		
21	Diagnostic Services	Yes	Yes
	Mental Health and Substance Use Disorder Services (including behavioral health treatment, counseling and psychotherapy)		
22	Intranasal opioid reversal agent associated with opioid prescriptions	No	No
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	Yes	Yes
24	Opioid Medically Assisted Treatment (MAT)	Yes	Yes
25	Substance Use Disorders (Including Inpatient Treatment)	Yes	Yes
26	Tele-Psychiatry	Yes	Yes
27	Topical Anti-Inflammatory acute and chronic pain medication	No	No

Consumer Coverage Disclosure Act (CCDA) Notice

for Residents of the State of Illinois (continued)

Illinois Essential Health Benefit (by Category)		Employer Plan "Covered Benefit"?	
		$250 Deductible	**HDHP**
Pediatric Oral and Vision Care (does not include adult dental and vision coverage)			
28	Pediatric Dental Care	No	No
29	Pediatric Vision Coverage	Yes	Yes
Pregnancy, Maternity, and Newborn Care (both before and after birth)			
30	Maternity Service	Yes	Yes
Prescription Drugs			
31	Outpatient Prescription Drugs	Yes	Yes
Preventive and Wellness Services / Chronic Disease Management			
32	Colorectal Cancer Examination and Screening	Yes	Yes
33	Contraceptive / Birth Control Services	Yes	Yes
34	Diabetes Self-Management Training and Education	Yes	Yes
35	Diabetic Supplies for Treatment of Diabetes	Yes	Yes
36	Mammography - Screening	Yes	Yes
37	Osteoporosis - Bone Mass Measurement	Yes	Yes
38	Pap Tests / Prostate- Specific Antigen Tests / Ovarian Cancer Surveillance Test	Yes	Yes
39	Preventive Care Services	Yes	Yes
40	Sterilization (women)	Yes	Yes
Rehabilitative and Habilitative Services and Devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)			
41	Chiropractic & Osteopathic Manipulation	Yes	Yes
42	Habilitative and Rehabilitative Services	Yes	Yes

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.