January 2024- December 2024

2024 BENEFITS ENROLLMENT

YOUR BENEFITS, YOUR STORY
Benefits to fit your unique situation

5 WAYS TO SAVE
On healthcare expenses

3 TIPS
For an easy enrollment

GTG
GRASK TRUCK GROUP
Peterbilt

TRUE NORTH
Insurance and Financial Strategies

WHAT'S CHANGING THIS ENROLLMENT

Medical rates:
Will have a minimal increase.

Dental enhancements:
Preventive services will now be covered at 100% and the annual maximum will be increasing to $1,500. Rates will have a minimal increase.

All Other Benefits will remain unchanged.

THINGS TO KNOW

5 WAYS TO SAVE

1. THINK ABOUT HOW YOU WILL USE YOUR BENEFITS.

- Do you have a chronic condition?
- Do you have surgery planned for this year?
- Are you adding any new dependents to your plan?

Consider these questions when choosing a plan.

2. MANAGE MEDICATION COSTS.

Ask your doctor to prescribe you generic medications. They can be just as effective and typically cheaper!

3. TRY MYCHART TELEMEDICINE OR URGENT CARE.

Telemedicine and urgent care can cost you much less than going to the ER and usually save you a lot of time.

4. STAY IN-NETWORK FOR CARE.

Think of it as an exclusive club. You may pay higher amounts if you go Out-of-Network.

5. PREVENTION IS KEY.

Prevention is key to catching disease or illness early on. Plus, preventive exams are often free or cost less than a normal doctor's visit.

3 TIPS FOR EASY ENROLLMENT

1. DON'T WAIT!

As a new hire this is your one chance to choose your benefits until our annual enrollment period. Your benefits will begin on the first of the month following 30 days.

After this enrollment period, the only way you'll be able to change your plans before the following enrollment period is if you have a **qualifying life event,** such as getting married or having a baby.

2. TO ENROLL OR NOT TO ENROLL?

This year you aren't required to enroll in and/or waive your benefits.

3. UP YOUR BENEFITS IQ

Have questions about your benefit options? Not sure what is right for you? Make sure to check out your benefits website at: www.mygtgbenefits.com and use the code benefits. And don't forget about the TrueAdvocate Team! They are available from 7:30 a.m. - 5 p.m. CST to answer your benefits questions. Just call 888-655-9980 OR email trueadvocate@truenorthcompanies.com.

The plan information outlined in this enrollment guide is intended to be a snapshot of the benefits and does not provide full plan details. For complete plan information and any policy restrictions, refer to your plan document. If any discrepancy exists between the summary displayed in this guide and the policy, the policy will govern.

BENEFITS BASICS

WELCOME TO YOUR 2024 BENEFITS!

Grask Truck Group benefits add value beyond your paycheck. They can make health care more affordable, provide income during a disability, and help you achieve financial goals.

As an employee of Grask Truck Group, you have a total compensation package - a combination of pay and benefit programs that is among the best in our industry. This guide describes the key features of our health, life and additional program offerings. They are designed to give you choices about the types and levels of protection that you want. As your needs change, you can continue to design a benefits program that best fits your life. Each year, you have the opportunity to review your choices and make new decisions.

This guide provides a brief summary of your Grask Truck Group benefits. Please take the time to review your options and learn about the coverages that will best work for you and your family!

This information is a highlight of our benefit program. In the event of any discrepancy or omission, actual benefits will be determined by the applicable governing plan documents. Grask Truck Group reserves the right to change or end any benefit at any time to the extent allowed by the law.

ELIGIBILITY

As a full-time employee of Grask Truck Group, you are eligible for benefits if you work at least 30 hours per week. Your benefits are effective 1st of the month following 30 days of employment. Your dependents can also enroll for coverage, including:

- Your legal spouse.
- Your children up to age 26.

DEPENDENT ELIGIBLIITY

As part of the responsibility and management of our benefit plan, we have to ensure that all covered dependents meet the eligibility requirements. We are asking all employees to certify that their dependents meet the definition of an eligible dependent prior to adding them to our plans.

Benefit Basics Definition of an eligible dependent:

- A lawful spouse of an employee, including a common law spouse if recognized by your state
- Children of an employee up to age 26
- Children age 26 or older who are mentally or physically handicapped
- A legally adopted child, a step-child, or a child placed in your care by court order, all under 26 years of age.

Falsification of the eligibility will result in coverage for the dependent being rescinded and may result in medical claims being denied.

QUALIFYING LIFE EVENTS

Generally, you may only make or change your existing benefit elections during the open enrollment window. However, you may change your benefit elections during the year if you experience an event such as:

- Gain or loss of other coverage
- Marriage
- Divorce or legal separation
- Birth of your child
- Death of your spouse or dependent child
- Adoption of or placement for adoption of your child
- Change in employment status of employee, spouse or dependent child
- Qualification by the Plan Administrator of a child support order for health coverages
- New entitlement to Medicare or Medicaid

Go to healthcare.gov for a full list of qualifying life events.

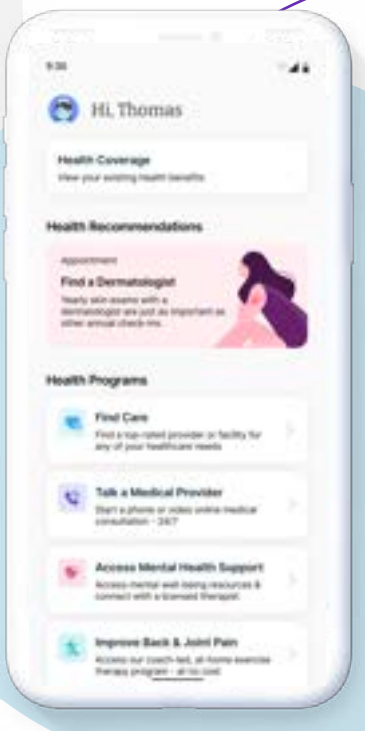
You must **notify Human Resources within 30 days** of a qualifying life event. If you do not contact Human Resources within 30 days of the qualified event, you will have to wait until the next open enrollment window to make changes.



HealthJoy Makes it Easier to be Healthy and Well.

HealthJoy

HealthJoy is the virtual access point for all your healthcare navigation and employee benefits needs. We're provided free by your employer to help understand and make the most of your benefits. We connect you and your family with the right benefits at the right moment in your care journey, saving you time, money, and frustration.



Help For Your Healthcare Journey.

With 24/7 access to our dedicated healthcare concierge team, visits, and care navigation tools, you never have to walk alone. HealthJoy helps you locate in-network doctors, find extra savings on your prescriptions, and navigate your benefits. Our mobile app and dedicated member support team are always on hand to help make it easier to stay healthy and well.

- BENEFITS WALLET
- HEALTHCARE CONCIERGE
- RX SAVINGS REVIEW
- APPOINTMENT BOOKING
- PROVIDER RECOMMENDATIONS
- HSA / FSA SUPPORT



"It saved me the time I would have spent Googling results, calling specialists, and searching for an appointment. Instead, I just put in the request, and HealthJoy did the work. The app is like my little assistant!"

Veronica, AZ

Chat with us today by logging into the HealthJoy app or call (877) 500-3212

Download on the App Store

GET IT ON Google Play

SCAN ME

Carrier Information for 2024

Medical coverage will continue to be with UMR!

UMR (short for United Medical Resources) was founded in 1983 and is considered a Third-Party Benefit Administrator (TPA). UMR is meant to give administrative assistance to a variety of health insurance plans that are self-funded.

UMR operates under the UnitedHealthcare umbrella – they are a TPA subset of UHC.

UMR utilizes the United Healthcare Choice Plus Network.

To search for an in-network provider, visit www.umr.com and select the "Find a provider" icon; then type in "UnitedHealthcare Choice Plus Network". If you have any network questions, please feel free to contact UMR directly, or reach out to the TrueAdvocate team at 888-655-9980.

EVEN MORE WAYS TO SAVE

Use tools from UMR to help you save more and get educated!
Register today at www.umr.com

- ✓ View doctors and hospitals within the UMR health plan network
- ✓ See YTD accumulations on your deductible and out-of-pocket max limits
- ✓ Get health answers any time you are confused about a term or benefit
- ✓ View, scan or fax your ID card for easy, on-the-go access
- ✓ Utilize the Health Cost Estimator tool to find best quality and lowest cost on any major services



Carrier Information for 2024

MedOne

https://members.medone-rx.com/

- MedOne will continue to be the Pharmacy Benefit Manager for Grask Truck Group for 2024.
- MedOne owns a National Pharmacy network and serves members in all 50 states.
- MedOne and UMR coordinate coverage, so anything paid towards prescriptions accumulates towards the out-of-pocket maximum on your health plan.
- **You will have a separate MedOne ID card for pharmacy.**



The member portal has lots of valuable information, including:

- Pharmacy locators
- Sample pricing for potential medications
- View claims detail & prescription history
- Enroll in Mail Order



Which Medical Plan Is Best For You?

UMR: 800-826-9781

WWW.UMR.COM

HOW TO FIND A NETWORK PROVIDER.

1. Visit the site below, click "Find a Provider".
2. Choose from the UHC Choice Plus Network.

Provider Search: www.umr.com

IN-NETWORK BENEFITS	PLAN 1
Deductible	$2,000 Single $4,000 Family
Coinsurance	You pay 40%, plan pays 60%
Out of Pocket Maximum	$4,550 Single $7,480 Family
Office Visit Copay	$0 PCP $50 Non-PCP $0 Captive Health Telemedicine $0 Urgent Care
Preventive Office Copay	Covered at 100%
Emergency Room Copay	$500 copay
Inpatient Hospital/ Outpatient Surgery	You pay 40% after deductible, plan pays 60%
Prescription Drug	
Deductible	$100 Single / $200 Family (waived for Tier 1)
Drug Tiers	$8/$35/$50
Specialty Drugs	Specialty Drugs filled through RxAlly Program

PER PAY PERIOD COST (WEEKLY)	
EMPLOYEE ONLY	$69.00
EMPLOYEE & SPOUSE	$166.21
EMPLOYEE & CHILD(REN)	$153.85
EMPLOYEE & FAMILY	$247.74

RxAlly™

PROCESS OVERVIEW

medone Pharmacy Benefit Solutions

Program Overview

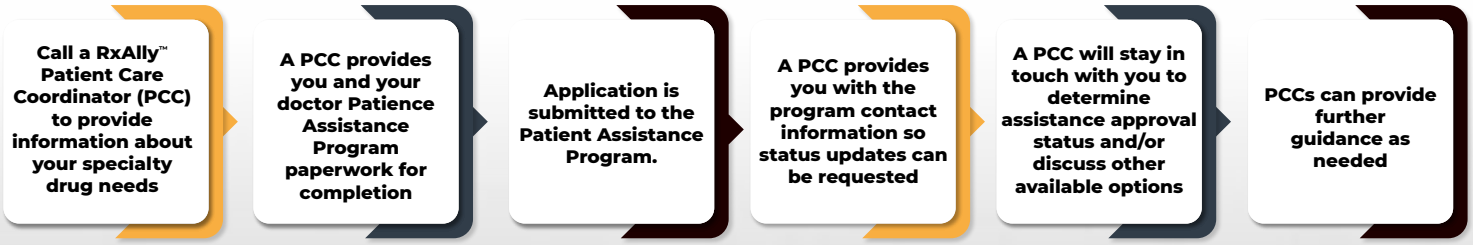
The RxAlly™ Specialty Advocacy Program is designed to help members secure access to specialty medications through Patient Assistance Programs. A specialty medication is a medication that treats complex medical conditions such as cancer, psoriatic arthritis, and multiple sclerosis, and often require specific handling and storage requirements.

Patient Assistance Programs can be offered by drug manufacturers to offer specialty drug coverage when coverage is not available under an employer sponsored prescription benefit plan. RxAlly™ provides help to members by identifying and coordinating application to these Patient Assistance Programs as the process can be complex. A designated RxAlly™ Patient Care Coordinator (PCC) will work directly with you and your doctor to gather, prepare, and apply for patient assistance. Once a RxAlly™ PCC submits both your portion and your doctor's portion of the application, the Patient Assistance Program will review the application and determine if you qualify for assistance. This review process can take a few days or even weeks. It is important that you call or email the Patient Assistance Program frequently to request the status of your application (this status check request must be made by the patient directly and not an outside party).

If your application is approved, please contact your Patient Care Coordinator to update your case accordingly. The Patient Assistance Program will work with you directly to provide instructions on how to obtain your medication. In most cases your medication will be shipped directly to you by the program's preferred specialty pharmacy.

If your assistance application is denied, please contact your dedicated Patient Care Coordinator as soon as possible to determine additional opportunities for accessing your requested medication.

Assistance Process Overview



Key Action Steps

1. Call a RxAlly™ Patient Care Coordinator (PCC) today at 877-794-2218 to enroll and provide information about your specialty drug.
2. Review & sign the prepared application by your PCC. We may also ask you to nudge your doctor in completing their portion of the paperwork if the PCC is unable to get a direct response.
3. Once the PCC submits the application, please call the program directly for a status update if you do not hear from them in 5-7 business days.
4. If you need your medication within the next 7 days please contact your PCC immediately and they will work your plan to determine a course of action.
5. Respond or reach out to your PCC with application status or any questions.

Questions?

Call **877-794-2218** to speak with a RxAlly™ Patient Care Coordinator.

www.medone-rx.com

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RXALLY

Frequently Asked Questions

What is a specialty medication?

Specialty drugs are used to treat complex conditions, can require frequent dosing adjustments and intensive monitoring to decrease the likelihood of adverse events, and improve treatment outcomes. They are often high-cost, treat rare conditions, and have specialty storage and delivery requirements.

Why do I have to change how I get my specialty medication?

The benefit you are requesting coverage from does not provide coverage for specialty medications. This may be a change from what was covered under the benefit in the past. This means you are unable to access your specialty medication in the same way you had previously. Your plan has partnered with RxAlly™ to provide additional support services to help you access your specialty medication through alternative programs.

What does the general process look like?

Members must call a RxAlly™ Patient Care Coordinator (PCC) to begin the process for obtaining their specialty medication.

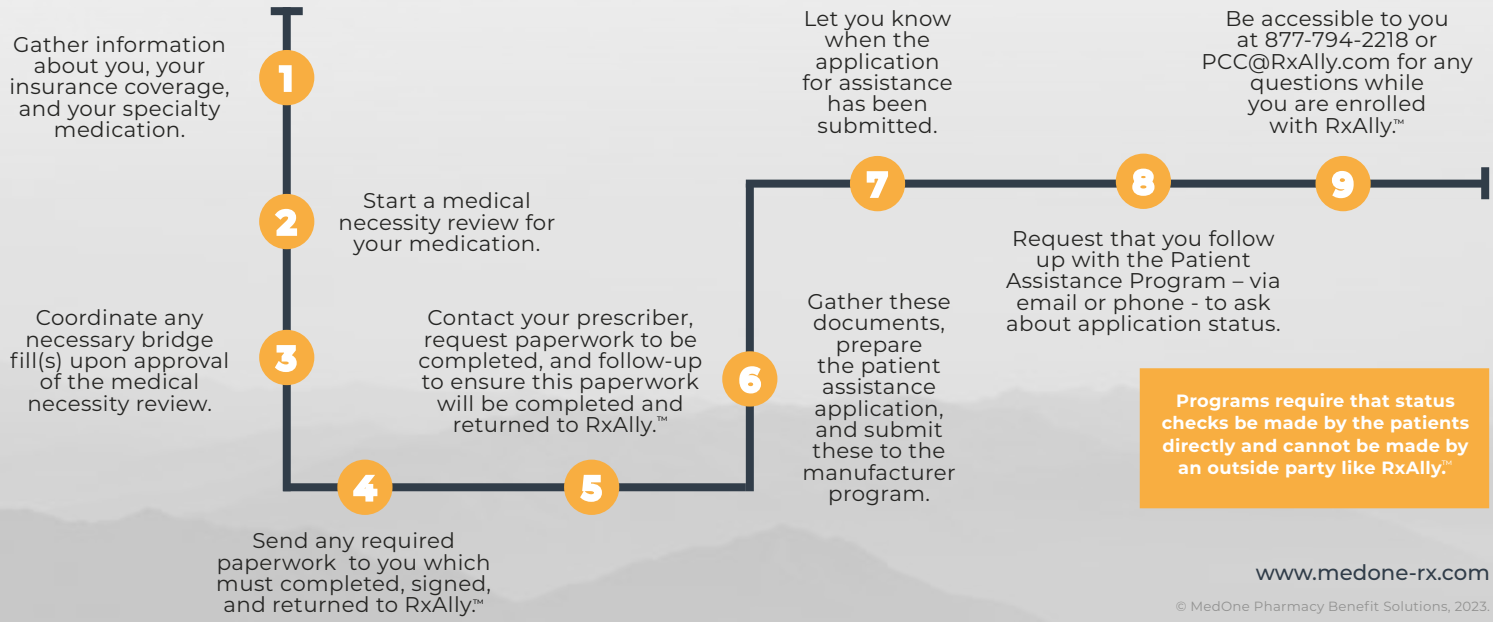
How do I fill my specialty medication?

Your RxAlly™ Patient Care Coordinator will be your resource in determining the best available options on how to access your specialty medication. Most patients will apply for access through a Manufacturer Patient Assistance Program (PAP) and receive their specialty medication at little to no cost. You, too, can secure your medication if you and your prescriber follow a few steps. Your Patient Care Coordinator will be your dedicated resource to help you along this journey.

What is a Patient Assistance Program (PAP)? And why do I need this?

Some drug manufacturers sponsor patient assistance programs (PAPs) that offer access to certain medications to eligible patients at little to no cost. In order to enroll in these services, which can include shipment of free medication straight to your door, an application to the PAP is require. Eligibility requirements include, but not limited to, prescription drug plan coverage, household income, and indication. Because your medication is excluded by your prescription drug plan, you are eligible for most PAPs.

Your RxAlly™ PCC will....



Programs require that status checks be made by the patients directly and cannot be made by an outside party like RxAlly.™

www.medone-rx.com

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What if I need to fill my specialty medication but my patient assistance application is still in process?

While your patient assistance application is in process, you may be eligible to receive your medication through a bridge fill. A bridge fill is a fill of your specialty medication through your prescription drug coverage administered by MedOne. Prior to receiving your bridge fill, a medical necessity review may need to be completed.

What does the medical necessity review process look like?

In general, all specialty drugs required a medical necessity review to verify that the medication is going to be used safely, effectively, and for an FDA-approved indication. Once you connect with a Patient Care Coordinator, they will start the medical necessity review process which typically takes a few days. The clinical team requests information from your physician about your therapy and makes a determination.

How long will it take before I find out if I'm approved from the Patient Assistance Program?

After your application has been submitted, the Patient Access Program will take anywhere from a few days to several weeks to review your application. They typically will take longer during busier times of the year, such as January through March. Unfortunately, the RxAlly™ Patient Care Coordinator is unable to contact the Patient Access Program directly for status updates as PAPs will only speak with patients directly. If you are waiting on a response from the Patient Assistance Program and are in need of your next fill of medication, contact your Patient Care Coordinator and they will determine the options available to support your continued access to treatment while waiting on a response.

Who is MedOne? I thought this program was called RxAlly™?

MedOne is the prescription benefit manager that administers your prescription benefit on behalf of your employer's sponsored prescription plan. RxAlly™ is a program operated separately from your prescription drug plan, which serves to support members whose plans exclude certain drugs.

Why is it only this specific medication that has to go through RxAlly™?

The RxAlly™ program supports patients in accessing any specialty medication. If your medication is classified as a specialty medication and excluded by your prescription drug plan, RxAlly™ provides additional support to identify alternative means to access your treatment. Patient Access Programs are available for most specialty medications, and patients who are unable obtain coverage through a commercial benefit are often eligible.

Is there an alternative medication I can take that doesn't involve a Patient Assistance Program?

If you wish to explore alternative therapies, please reach out to your prescriber. In general, any medications classified as specialty are excluded by the plan and are eligible for support from a RxAlly™ Patient Care Coordinator. Medications that are not classified as specialty may be covered by your plan and accessible through your prescription benefit. You, or your prescriber, may contact MedOne at 888-884-6331 to determine covered alternative medications.

What is the difference between copay assistance and patient assistance?

Copay Assistance Programs and Patient Assistance Programs are both offered by drug manufacturers to help limit financial barriers for patients to access their medications. Copay Assistance Programs help cover part or all of an insured, eligible.

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patient's financial responsibility for their specialty medication. Patient Assistance Programs support patients whose prescription plan does not provide coverage for certain medications. Patients must complete an application and meet certain eligibility requirements to obtain medications at no cost.

Is there a coupon for my medication to help cover the cost of my bridge fill?

Patients may use Copay Assistance Programs for assistance in covering the cost of bridge fills to reduce their out-of-pocket expense. It is common to have patients enroll in both a Patient Assistance Program and Copay Assistance Program simultaneously. There may be a coupon available for your specialty medication to reduce your copay. Contact your Patient Care Coordinator to see if your medication is eligible for Copay Assistance as well as Patient Assistance.

What is required of me?

Your designated RxAlly™ Patient Care Coordinator will send you a patient assistance application through your preferred method of communication (email, fax, or mail). You will fill out the information needed, sign as indicated, and return this paperwork to RxAlly™ along with a copy of your most recent 1040 tax document, and a copy of your insurance card(s).

Why do I have to provide my tax/income information?

Nearly all patient assistance programs have an income eligibility requirement and will need proof of income to verify this. Therefore, your PCC may request a copy of your most recent 1040, W2, and/or pay stub history. Most PAPs set their income requirement between 400-600% of the Federal Poverty Level (FPL) which can be calculated here: **www.needymeds.org/FPL_Calculator**

How do I return this application to RxAlly™?

The Patient Care Coordinators can receive this information through secure email, secure fax, or through mail.

Secure Email: PCC@RxAlly.com
Fax: 855-476-4062
Mail: 1590 University Avenue
Dubuque, IA 52001

Why do I have to reach out to the Patient Assistance Program for status updates once the application is submitted?

The Patient Assistance Programs will only speak to the patient and not to outside parties, like RxAlly.™ We are happy to assist in enrolling in the Patient Assistance Program and in gathering any information required, but once enrolled, you will have to reach out to the program for any status updates personally.

What happens if I get denied by the Patient Assistance Program?

Do not fret! It is common that we see denials on initial submissions. Our Patient Care Coordinators are here to aid you in these situations and can provide direction on how to complete a second submission. We will explore all avenues for available coverage: it is our goal that you do not go without your medically necessary medication. Please call your Patient Care Coordinator as soon as possible once you have heard a determination from the Patient Assistance Program.

What do I do if I have any questions?

Your Patient Care Coordinator would be happy to answer any questions you may have. We are also able to schedule a consultation with a clinical pharmacist should you have questions regarding your specialty medication. Please call your Patient Care Coordinator at 877-794-22181 or email at PCC@RxAlly.com for additional assistance.

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Telemedicine via MyChart

Captive Health

REDUCING RISK - IMPROVING HEALTH



DISCOVER THE COMPASSIONATE CARE YOU DESERVE FROM ANYWHERE COMPLETELY FREE

Captive Health Telemedicine, in collaboration with MyChart, delivers convenient and high-quality healthcare at your fingertips, ensuring exceptional care precisely when you need it. Whether it's 2 a.m. and you're battling flu-like symptoms or you're feeling unwell during a vacation, rest assured, we're here to provide you with comprehensive support. Our mission is to make your life easier and healthier, whether addressing a sudden concern or managing your well-being.



VISIT FOR ACCESS TO TELEMEDICINE
HTTPS://MYCHART.CAPTIVEHEALTH.ORG



WHY WE ARE DIFFERENT

- Instant assess, breaking geographical barriers
- Consistent connection with healthcare providers
- Provide higher level of privacy and confidentiality
- Designed exclusively for You and Your Family
- 24/7 access from anywhere in the United States
- Bridge healthcare gaps in rural and underserved areas
- Quicker access to address acute or urgent medical needs
- Cost effective, no copay & decrease traveling expenses

Captive Health is passionately committed to delivering the ultimate telemedicine experience enhanced by your care provider seeing current medications, allergies, and past medical history. After your visit, your primary care provider can be informed of pertinent outcomes and follow-up needs to better coordinate care.

LEARN HOW TO ACCESS TELEMEDICINE VIA A NEW MYCHART ACCOUNT

LEARN HOW TO ACCESS TELEMEDICINE VIA EXISTING MYCHART ACCOUNT

GRASK TRUCK GROUP
10/1/2023 TO 12/31/2023

The Grask Truck Group wellness program is partnered with Captive Health to offer employees and spouses services such as health risk assessment, wellness coaching, and care management of ongoing health conditions. Grask Truck Group wellness program rewards employees for maintaining or working toward good health to help ensure healthy, happy employees in the future.

PROGRAM REQUIREMENTS TO COMPLETE IN ORDER TO RECEIVE 10% PREMIUM HEALTH INSURANCE DISCOUNT

✓ **Annual Physical with Primary Care Provider plus Labs**
- The PCP screening form is located on the wellness portal. Please print the form, take to your appointment, and email completed form and lab results to salbers@captivehealth.org in order to receive credit towards your program requirements.

✓ **Annual Health Risk Assessment (HRA)**
- Log into HealthyJoy, go to your wellness portal, and the HRA will pop up upon opening.

✓ **Annual Nicotine-Free Affidavit**
- Log into HealthJoy, go to your wellness portal, and complete the nicotine-free affidavit.

✓ **Spousal Participation-**
- Spouses on the healthcare plan are required to participate in the wellness program and care management (if eligible) in order to receive health insurance discount.

LEARN MORE ABOUT YOUR WELLNESS PROGRAM

All personal health information is confidential and protected under the federal HIPAA regulations.

Care Management of Ongoing Health Conditions-Support and advocacy services offered in the management of ongoing health conditions.
- Care manager will review health history and address any gaps in healthcare needs.
- This service is based on specific qualifying factors, check out the wellness portal to explore.
- If eligible, you are required to participate and our care manager may reach out to you through a phone call.

Wellness Coaching Support-All employees and spouses are encouraged to take advantage of individual health coaching. The coach will work hand in hand with you to define your health goals and strategize ways to overcome obstacles.
- Interested in learning more or participating?
- Please contact wellness coach Suzi-salbers@captivehealth.org

Ready to take the step to quit nicotine-Participate in a five-week tobacco/vaping cessation program that assists you in creating a personalized plan to help you quit.
- For more details contact MercyCare BHS at (319) 369-4455 or dwaldron@mercycare.org

QUESTIONS?

Wellness Coach Suzi
salbers@captivehealth.org
(319) 449-0480

Dental Plan

DELTA DENTAL: 800-544-0718

WWW.DELTADENTALIA.COM



MEDICAL INSURANCE DOESN'T ALWAYS COVER OTHER TYPES OF CARE.

That's why we offer you the option to enroll in a separate dental plan. Please see a summary of your plan below and review the full plan summary or Certificate of Coverage for details.

HOW TO FIND A NETWORK PROVIDER.

1. Visit the site below, click "Fina a Provider".
2. Choose from the Premier Network.

Provider Search:
www.deltadentalia.com

SERVICES	PREMIER DENTIST
Preventive Services	Covered at 100%
Deductible	$50 Single / $150 Family
Basic Services	You pay 20% coinsurance (after deductible), plan pays 80%
Major Services	You pay 50% coinsurance (after deductible), plan pays 50%
Annual Maximum	$1,500 per person per year
Orthodontia For dependent children up to age 19	Not Covered

PER PAY PERIOD COST (WEEKLY)	
EMPLOYEE ONLY	$3.97
EMPLOYEE & SPOUSE	$12.00
EMPLOYEE & CHILD(REN)	$12.00
EMPLOYEE & FAMILY	$12.00

Vision Plan

EYEMED: 866-939-3633

WWW.EYEMED.COM



MEDICAL INSURANCE DOESN'T ALWAYS COVER OTHER TYPES OF CARE.

That's why we offer you the option to enroll in a separate vision plan. Please see a summary of your plan below and review the full plan summary or Certificate of Coverage for details.

HOW TO FIND A NETWORK PROVIDER.

1. Visit the site below, click "Members & Consumers" then "Find An Eye Doctor".
2. Choose from the Insight Network.

Provider Search:
www.eyemed.com

SERVICES	IN-NETWORK MEMBER COST
Exam 1 every 12 months	$10
Contacts 1 every 12 months	**Please note:** Contact lenses are in place of lenses and frame. • $10 for elective contact lens exam • $0 copay, $130 allowance for conventional/disposable lenses • Medically Necessary contacts: Covered in Full
Frames 1 every 24 months	• $130 allowance and 20% off the amount over your allowance
Lenses 1 every 12 months	Single, Bifocal, Trifocal, Lenticular: $25 copay Standard Progressive Lenses: $90 copay Premium Progressive Lenses: $110 - $135 copay

PER PAY PERIOD COST (WEEKLY)	
EMPLOYEE ONLY	$1.58
EMPLOYEE & SPOUSE	$3.00
EMPLOYEE & CHILD(REN)	$3.16
EMPLOYEE & FAMILY	$4.65

Employee Assistance Program

Captive Health

REDUCING RISK - IMPROVING HEALTH



WE PROVIDE EXEPTIONAL ACCESS AND EXPERIENCE

Employee assistance program (EAP) is a benefit provided by Captive Health for you and your family. EAP is intended to aid employees and their family members in addressing challenges impacting their personal lives and/or work performance.







WHY WE ARE DIFFERENT

- Unlimited counseling sessions per family
- In person, video, and phone session options
- Assessment and short-term, solution based focus
- Convienent locations in the Corridor
- Referral and follow-up services
- Experienced, Licensed Mental Health Counselor and Social Workers

BENEFITS TO USING EAP

Captive Health's EAP is dedicated to enhancing both your personal and professional life. We're here to tackle any issue, whether it's managing stress, nurturing relationships, maintaining work-life balance, or addressing mental health concerns. From everyday challenges to significant life transitions, our support covers it all. Your well-being is our priority.

MAKE AN APPOINTMENT

319-398-6575

YOUR ENROLLMENT BLUEPRINT

Remember, your annual enrollment period is from **December 4th-December 13th** .
Here are some last-minute reminders:

STEP 01

VISIT YOUR BENEFITS PORTAL

Website: www.mygtgpbbenefits.com
Login: Benefits

STEP 02



ATTEND ENROLLMENT MEETINGS

Please see flyer for location days & times!



STEP 03

EVALUATE YOUR OPTIONS

- **Review available benefit options for the year.**
- **Use carrier resources and tools to make decisions.**



STEP 04

ENROLL IN YOUR BENEFITS

- **Adds/Terms/Changes must complete an applicable carrier form and return to HR by 12/13/23**

NEED HELP DECIDING?

Contact TrueNorth's TRUEADVOCATE TEAM
Phone: 888-655-9980
trueadvocate@truenorthcompanies.com

Need Help?

Contact these Enrollment VIPs for Assistance!

Medical
UMR
800-826-9781
www.umr.com

Pharmacy Benefit Manager
MedOne
888-884-MED1
https://medone-rx.com/

Telemedicine
Captive Health
mychart.captivehealth.com

Dental
Delta Dental of IA
800-544-0718
www.deltadentalia.com

Vision
EyeMed
866-939-3633
www.eyemed.com

Grask Truck Group Benefit Portal
https://mygtgbenefits.com

Password: benefits

Human Resources
Judy Oberholser
HR & Talent Manager
Ph: 319-777-0743
joberholser@gtgpb.com

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Notes

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.umr.com or by calling \1-800-826-9781. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.umr.com or call 1-800-826-9781 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$2,000 person / $4,000 family In-network $2,250 person / $4,500 family Out-of-network	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	Yes. $100 person / $200 family per calendar year for drug card, which does not apply to the Generic tier. There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out–of–pocket limit for this plan?	$4,550 person / $7,480 family In-network $5,300 person / $10,600 family Out-of-network	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Penalties, premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.umr.com or call 1-800-826-9781 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.
	All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge; Deductible Waived	50% Coinsurance	None
	Specialist visit	$50 Copay per visit; Deductible Waived	50% Coinsurance	None
	Preventive care/screening/ immunization	No charge; Deductible Waived	50% Coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge PCP; $50 Copay per visit specialist; Deductible Waived Office setting; 40% Coinsurance Outpatient setting	50% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	40% Coinsurance	50% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.medone-rx.com or by calling 888-884-6331.	Generic drugs	$8 copay	NA	Bowel Preparation medications: $0 copay. Limited to 1 per year Breast Cancer chemo prevention: $0 copay. Prior authorization required. Contraceptives: Up to a 91-day supply is available at a $0 co-pay at MedOne Mail-Order Pharmacy. Vaccinations: The following are available at a $0 copay: Flu, Pneumonia, Shingles, Whooping Cough Check with retail network pharmacies for availability Over-the-Counter (OTC) Drugs: OTC smoking cessation products will be covered by the plan at $0 co-pay. Ask your physician to write a prescription specifically for OTC items. Statins for primary prevention of CVD: Select low to moderate dose statins are free for members when used for primary prevention of CVD in high risk patients between ages 40-75
	Brand drugs	$35 copay	NA	
	Non-Preferred Brand drugs	$50 copay	NA	
	Specialty drugs	Covered through RxAlly – A MedOne Program.	NA	Prescription Drug assistance through RxAlly is offered as part of your plan's prescription drug coverage. RxAlly Patient Care Coordinators will help you pursue drug manufacturer assistance programs and/or patient assistance programs. With many of these programs, your responsibility toward your prescription drug copay may be reduced or eliminated altogether. Coverage for certain prescription drugs may be available

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
				under the prescription drug benefit if RxAlly Coordinators are unable to obtain assistance programs for eligible Prescription Drugs. For help in acquiring Specialty Prescription Drug assistance, information about the RxAlly Program, or a list of eligible drugs, please call RxAlly at 877-794-2218.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% Coinsurance	50% Coinsurance	None
	Physician/surgeon fees	40% Coinsurance	50% Coinsurance	None
If you need immediate medical attention	Emergency room care	$500 Copay per visit; Deductible Waived	$500 Copay per visit; Deductible Waived	Copay may be waived if admitted
	Emergency medical transportation	40% Coinsurance	40% Coinsurance	In-network deductible applies to Out-of-network benefits
	Urgent care	No charge; Deductible Waived	50% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	40% Coinsurance	50% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Physician/surgeon fees	40% Coinsurance	50% Coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	No charge; Deductible Waived Office visits; 40% Coinsurance other outpatient services	50% Coinsurance	Preauthorization is required for Partial hospitalization. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Inpatient services	40% Coinsurance	50% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
If you are pregnant	Office visits	No charge; Deductible Waived	50% Coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	40% Coinsurance	50% Coinsurance	
	Childbirth/delivery facility services	40% Coinsurance	50% Coinsurance	
If you need help recovering or have other special health needs	Home health care	40% Coinsurance	50% Coinsurance	90 Maximum visits per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Rehabilitation services	$50 Copay per visit; Deductible Waived	50% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
	Habilitation services	$50 Copay per visit; Deductible Waived	50% Coinsurance	Habilitation services for Learning Disabilities are not covered.
	Skilled nursing care	40% Coinsurance	50% Coinsurance	90 Maximum days per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Durable medical equipment	40% Coinsurance	50% Coinsurance	Preauthorization is required for DME in excess of $500 for rentals or $1,500 for purchases. If you don't get preauthorization, benefits could be reduced by $500 per occurrence.
	Hospice service	40% Coinsurance	50% Coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture	• Hearing aids	• Routine eye care (Adult)
• Bariatric surgery	• Infertility treatment	• Routine foot care
• Cosmetic surgery	• Long-term care	• Weight loss programs
• Dental care (Adult)	• Private-duty nursing	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Chiropractic care	• Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.HealthCare.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.HealthCare.gov. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.HealthCare.gov and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

Does this plan Provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan Meet the Minimum Value Standard? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,000
Specialist copayment	$50
Hospital (facility) coinsurance	40%
Other coinsurance	40%

This EXAMPLE event includes services like:
Specialist office visits *(pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$300
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$4,600**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,000
Specialist copayment	$50
Hospital (facility) coinsurance	40%
Other coinsurance	40%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$200
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$520**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,000
Specialist copayment	$50
Hospital (facility) coinsurance	40%
Other coinsurance	40%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,300
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$2,010**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.umr.com or call 1-800-826-9781.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?"" row above.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Annual Notices Packet 2023-2024

Important Notices from Grask Truck Group regarding the Health & Welfare Plan

The following notices provide important information about the group health plan provided by your employer. Please read the attached notices carefully and keep a copy for your records.

If you have any questions regarding any of these notices, please contact:

General Contact

Name	Judy Oberholser
Phone	319-777-0743
Email	joberholser@gtgpb.com
Mailing Address	9201 6th St. SW
	Cedar Rapids, IA 52404

Distribution Date: December 2023 or upon hire

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Medicare Creditable Coverage Letter

Important Notice from Grask Truck Group About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Grask Truck Group 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. Grask Truck Group has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current Grask Truck Group coverage may be affected.

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

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

You should also know that if you drop or lose your current coverage with Grask Truck Group 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 your Plan Administrator 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 Grask Truck Group changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at ssa.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).

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Women's Health and Cancer Rights Act Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator for more information.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the 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
- Treatment of physical complications of the mastectomy, including lymphedema

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator.

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Newborns' and Mothers' Health Protection Act

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

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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.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa or call 1-866-444-EBSA (3272).

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

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ALABAMA – Medicaid

Website: http://myalhipp.com
Phone: 855-692-5447

ALASKA – Medicaid

The Alaska Health Insurance Premium Payment Program
Website: http://myakhipp.com
Phone: 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: 800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com/
HIBI Customer Service: 855-692-64422

FLORIDA – Medicaid

Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 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

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip
Phone: 877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid
Phone 800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 800-257-8563
HIPP Website:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov
Phone: 800-792-4884
HIPP Phone: 800-967-4660

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KENTUCKY – Medicaid

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

LOUISIANA – Medicaid

Website: https://ldh.la.gov/subhome/1 or http://www.ldh.la.gov/lahipp
Phone: 888-342-6207 (Medicaid hotline) or 855-618-5488 (LaHIPP)

MAINE – Medicaid

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

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 800-862-4840
TTY: 771
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 800-657-3739

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: 800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

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

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 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: 800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org
CHIP Phone: 800-701-0710

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid
Phone: 800-541-2831

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NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: https://www.hhs.nd.gov/healthcare
Phone: 844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 888-365-3742

OREGON – Medicaid

Website: http://healthcare.oregon.gov
Phone: 800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website:
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 800-692-7462
CHIP Website:
https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: https://eohhs.ri.gov/
Phone: 855-697-4347, or 401-462-0311
(Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov
Phone: 888-549-0820

SOUTH DAKOTA – Medicaid

Website: https://dss.sd.gov/medicaid/default.aspx
Phone: 888-828-0059

TEXAS – Medicaid

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

UTAH – Medicaid and CHIP

Medicaid Website: https://medicaid.utah.gov
CHIP Website: https://chip.health.utah.gov
Phone: 877-543-7669

VERMONT– Medicaid

Website:
https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 800-250-8427

VIRGINIA – Medicaid and CHIP

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

WASHINGTON – Medicaid

Website: https://www.hca.wa.gov
Phone: 800-562-3022

WEST VIRGINIA – Medicaid and CHIP

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

WISCONSIN – Medicaid and CHIP

Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 800-362-3002

WYOMING – Medicaid

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

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To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
https://www.cms.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)

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Wellness Program – Notice of Reasonable Alternatives

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 Captive Health or HR 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.

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Notice Regarding Wellness Program

Grask Truck Group in partnership with Captive Health is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of 10% for completing program requirements. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the 10% incentive.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Captive Health or HR.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

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

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

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In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Captive Health or HR.

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HIPAA Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

If not attached to this document, you may request a copy of the current Privacy Practices, explaining how medical information about you may be used and disclosed and how you can get access to this information.

As Required by Law. We will disclose Health Information when required to do so by international, federal, state, or local law.

You have the right to:

- Inspect and copy records
- Receive an electronic copy of electronic medical records
- Get notice of a breach
- Amend records
- Receive an accounting of disclosures
- Request restrictions
- Request confidential communications
- Receive a paper copy of this notice
- File a complaint if you believe your privacy rights have been violated

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete.

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	• 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 or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care.
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 you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information 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 https://www.hhs.gov/hipaa/filing-a-complaint/what-to-expect/index.html. • We will not retaliate against you for filing a complaint.

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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 car
- 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.*

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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. For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues	We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	We can use or share your information for health research.
Comply with the law	We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	We can share health information about you in response to a court or administrative order, or a subpoena.

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Our Responsibilities

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

For more information see: www.hhs.gov/hipaa/for-individuals/notice-privacy-practices/index.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

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Notice of Special Enrollment Rights

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact your Plan Administrator.

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Continuation Coverage Rights Under COBRA

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

- The parent-employee dies
- The parent-employee's hours of employment are reduced
- The parent-employee's employment ends for any reason other than his or her gross misconduct
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both)
- The parents become divorced or legally separated
- 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
- 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.

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

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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, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an eight-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.

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

General Contact

Name	Judy Oberholser
Phone	319-777-0743
Email	joberholser@gtgpb.com
Mailing Address	9201 6th St. SW
	Cedar Rapids, IA 52404

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For the Department of Labor's Employer Exchange/Marketplace Notices and Instructions, visit: http://www.datair.com/PDF/DOL Employer Exchange Notices.pdf

New Health Insurance Marketplace Coverage Options and Your Health Coverage | For Employers that Offer a Health Plan to Some or All Employees

PART A: General Information

When key parts of the health care law took effect in 2014, a new option for health insurance was made available: the Health Insurance Marketplace Exchange. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

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

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

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

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

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

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution – as well as your employee contribution to employer-offered coverage – is often

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excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your Plan Administrator.

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

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

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PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Grask Truck Group		4. Employer Identification Number (EIN) 39-1908322
5. Employer address 9201 6th St. SW		6. Employer phone number 319-777-0503
7. City Cedar Rapids	8. State IA	9. ZIP Code 52404
10. Who can we contact about employee health coverage at this job? Judy Oberholser		
11. Phone number (if different from above)	12. Email address joberholser@gtgpb.com	

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

As your employer, we offer a health plan to:

X Spouses, natural child, legally adopted or placed for adoption child, child for whom member has legal guardianship, stepchild. All employees. Eligible employees are:

All Full-Time employees or Part-Time employees working at least 30 hours per week.

With respect to dependents:

X We do offer coverage. Eligible dependents are:

Spouses, natural child, legally adopted or placed for adoption child, child for whom member has legal guardianship, stepchild.

X If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

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If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

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To comply with the No Surprises Act, group health plans and health insurance issuers offering group or individual health insurance coverage must make publicly available, post on a public website of the plan or issuer, and include on each Explanation of Benefits, information in plain language on the restrictions on balance billing in certain circumstances, any applicable state law protections against balance billing, the requirements of the Act, and information on contacting appropriate state and federal agencies to report suspected violations of these balance billing restrictions. Plans and issuers may use this model notice to meet the disclosure requirements. For more information and further instructions, see https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance, or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You *can't* be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing

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amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers *can't* balance bill you and may *not* ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers *can't* balance bill you, unless you give written consent and give up your protections.

You're *never* required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, contact your Plan Administrator or the federal phone number for information and complaints is 1-800-985-3059.

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law. [

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