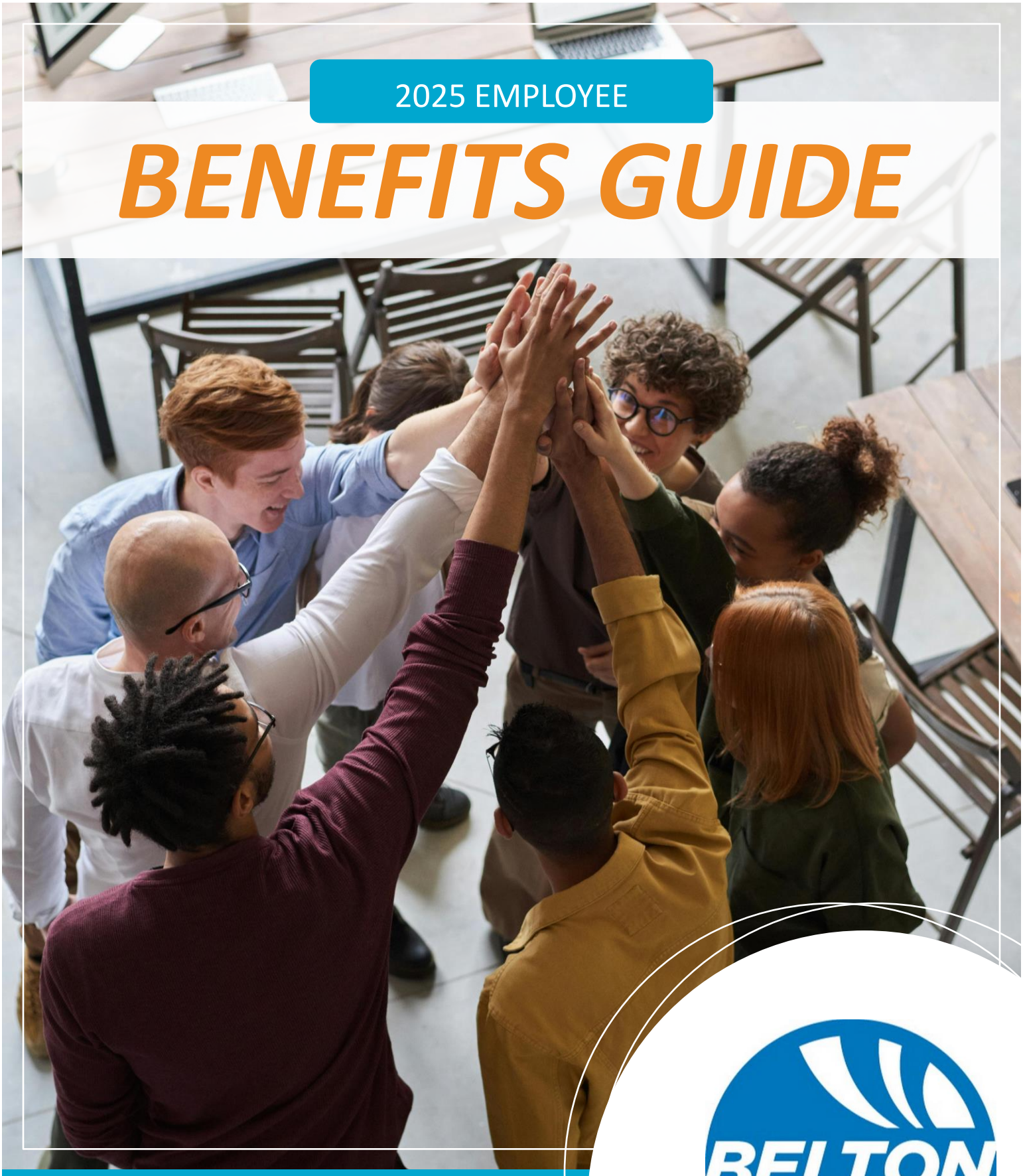
2025 EMPLOYEE

BENEFITS GUIDE



BELTON

Effective as of 10/22/2024

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ENROLLMENT & ELIGIBILITY

Your Benefits

The City of Belton believes your benefits are an important part of your overall compensation and work year-round. Our goal is to provide you with the most competitive and comprehensive benefits program that is affordable for all.

This Employee Benefits Guide is intended to provide a broad overview of your benefits and is presented for illustrative purposes only. More detailed information is included in the Plan Documents, which are available in Employee Navigator or by request through the Human Resources Department. In the case of a discrepancy, the actual plan documents will prevail.

Who is Eligible?

Full-Time Employees:

Benefits are effective the first day of the month following 60 days of employment. If you are a full-time employee, you are eligible for our full benefits package.

Dependents:

If you are eligible to enroll in the benefit plans, you may also enroll your eligible family members including:

- your legally married spouse
- children up to age 26 (natural born children, legally adopted children, step-children, and children for whom you are the legal guardian)

How Do I Change Coverage During the Year?

Once you elect your benefits, you cannot change your elections until the next annual open enrollment period, unless you experience one of the following qualifying life changes

- Marriage, divorce or legal separation
- Birth or adoption
- Dependent's loss or gain of coverage or eligibility
- Job loss or reduction in work hours
- Medical Child Support Order
- Death of a dependent
- Change in Medicaid/CHIP Status
- Entitlement to Medicare

Changes must be made within 30 days of the qualifying event. If they are not made during that time, you must wait until the next open enrollment period to make changes.

To make a change, submit the qualifying event through Employee Navigator, and contact Human Resources if you have questions.

HOW TO ENROLL

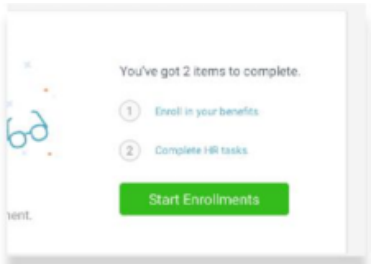
Where & When Can I Enroll?

Open Enrollment will be held Wednesday, October 23 to Thursday, November 14, 2024. During this time, you can login to Employee Navigator at www.employeenavigator.com using your user ID and password to enroll.

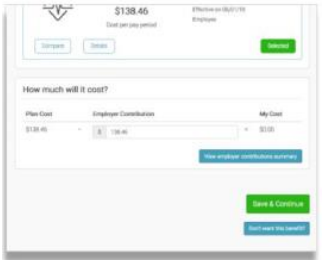
Or you can:
Use your phone's camera to scan the QR Code and quickly access the website.

Show Me How

STEP 1: After you have logged in, click **"Start Enrollment."** You'll need to complete some personal & dependent information before moving to your benefit elections.



STEP 2: To enroll dependents in a benefit, click the checkbox next to the dependent's name under **"Who am I enrolling?"**



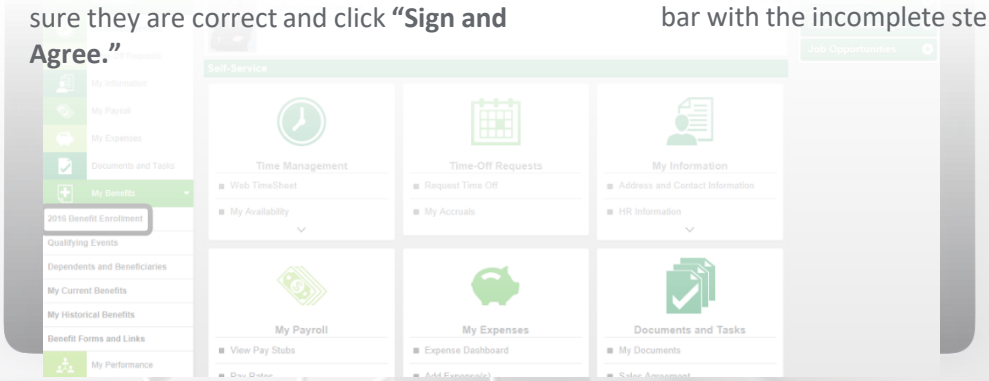
STEP 3: Below your dependents you can view your available plans and the cost per pay. To elect a benefit, click **"Select Plan"** underneath the plan cost. Then click **"Save & Continue"** at the bottom of each screen to save your elections.

STEP 4: If you don't want a benefit, click **"Don't want this benefit?"** at the bottom of the screen and select a reason from the drop-down menu.

STEP 5: If you have elected benefits that require a beneficiary designation or completion of an Evidence of Insurability form, you will be prompted to add in those details.

STEP 6: Review the benefits you selected on the enrollment summary page to make sure they are correct and click **"Sign and Agree."**

TIP: If you miss a step you'll see **"Enrollment Not Complete"** in the progress bar with the incomplete step highlighted.



MEDICAL OVERVIEW

The City of Belton offers three medical plans through Aetna: a **Qualified High Deductible Plan**, a **PPO Plan** and an **EPO Plan.**

You may use the health care provider of your choice; however, you will receive greater benefits by seeing an in-network provider. Participating network providers have agreed to considerably discount their services, so you pay less out-of-pocket.

Medical Plans Overview

	HDHP	PPO Plan	EPO Plan
Deductible	*In Network / Out-of-Network*		*In-Network Coverage Only*
Single	$3,300 / $6,600	$2,000 / $4,000	N/A
Family	$6,400 / $12,000	$4,000 / $8,000	N/A
Coinsurance			
Member Pays	20% / 50%	20% / 50%	$0
Out-of-Pocket Maximum			
Single	$4,000 / $8,000	$5,000 / $10,000	$5,500
Family	$8,000 / $16,000	$10,000 / $20,000	$11,000

Which Medical Plan is Right for Me?

All three medical plans offer unique benefits. The following pages will review each plan and what they offer so you can make the best decision for you and your family.

HDHP PLAN

Plan Summary (HDHP with HSA)

For this plan, you pay all your healthcare expenses until you meet the deductible. The plan can also be accompanied by a Health Savings Account (HSA) See page 16 for more information regarding HSA's. The HDHP utilizes Aetna's Open Choice PPO Network of providers.

Medical/Rx Plan Design	Aetna HDHP	
Schedule of Benefits	**In-Network**	**Out-of-Network**
Deductible *(per calendar year)*	Embedded Deductibles	
Individual	$3,300	$6,000
Family	$6,600	$12,000
Coinsurance	20%	50%
Out-Of-Pocket Max. *(includes deductible, copays, coinsurance, RX copays and RX coinsurance)*		
Individual	$4,000	$8,000
Family	$8,000	$16,000
Physician Services		
Preventive Care	Covered 100%	Ded + 50%
Primary Care Office Visits	Ded + 20%	Ded + 50%
Specialist Office Visits	Ded + 20%	Ded + 50%
Emergency Services		
Emergency Room Visit	Ded + 20%	
Urgent Care	Ded + 20%	Ded + 50%
Inpatient/Outpatient Services		
Inpatient Care	Ded + 20%	Ded + 50%
Outpatient Surgery	Ded + 20%	Ded + 50%
Diagnostic Lab / X-Ray	Ded + 20%	Ded + 50%
High Tech Scans *(MRI, CT, etc.)*	Ded + 20%	Ded + 50%
Physical/Occupational/Speech Therapy	Ded + 20%	Ded + 50%

Prescription Drugs	Retail	Mail Order
Retail Preferred Specialty Non-Preferred Specialty	After Deductible: $15 / $50 / $85 20% to $150 Max 20% to $250 Max	After Deductible $37.50 / $125 / $212.50

Monthly Contributions	Employee Contribution	City Contribution
Employee Only	$0.00	$885.89*
Employee + Spouse	$84.74	$1,793.25
Employee + Child(ren)	$84.74	$1,793.25
Employee + Family	$303.40	$1,799.66

**Includes the City's contribution to the Employee's HSA*

PPO PLAN

Plan Summary (PPO Plan)

This plan is a traditional PPO plan with copays for office visits and prescription drugs. The Base PPO Plan utilizes Aetna's Open Choice PPO network of providers.

Medical/Rx Plan Design	Aetna PPO	
Schedule of Benefits	**In-Network**	**Out-of-Network**
Deductible *(per calendar year)*	Embedded Deductibles	
Individual	$2,000	$4,000
Family	$4,000	$8,000
Coinsurance	20%	50%
Out-Of-Pocket Max. *(includes deductible, coinsurance, RX copays and RX coinsurance)*		
Individual	$5,000	$10,000
Family	$10,000	$20,000
Physician Services		
Preventive Care	Covered 100%	Ded + 50%
Primary Care Office Visits	$30 Copay	Ded + 50%
Specialist Office Visits	$60 Copay	Ded + 50%
Emergency Services		
Emergency Room Visit	$200 Copay then Ded + 20%	
Urgent Care	$50 Copay	Ded + 50%
Inpatient/Outpatient Services		
Inpatient Care	Ded + 20%	Ded + 50%
Outpatient Surgery	Ded + 20%	Ded + 50%
Diagnostic Lab / X-Ray	Ded + 20%	Ded + 50%
High Tech Scans *(MRI, CT, etc.)*	Ded + 20%	Ded + 50%
Physical/Occupational/Speech Therapy	Ded + 20%	Ded + 50%

Prescription Drugs	Retail	Mail Order
Retail Preferred Specialty Non-Preferred Specialty	$10 / $45 / $70 / 20% to a $150 Max 20% to $250 Max	$25 / $112.50 / $175

Monthly Contributions	Employee Contribution	City Contribution
Employee Only	$0.00	$885.89
Employee + Spouse	$307.94	$1,776.61
Employee + Child(ren)	$307.94	$1,776.61
Employee + Family	$574.88	$1,759.51

EPO PLAN

Plan Summary (EPO Plan)

The EPO Plan only includes coverage for In-Network services. If you see an Out-of-Network provider, you will not have coverage. **This plan utilizes Aetna's (KS/MO) KC Care Network Plus – Choice POS II Network, which excludes St. Luke's Hospitals and Providers and Prime Hospitals (which includes St. Joseph's, St. Mary's & Providence).**

Medical/Rx Plan Design	Aetna EPO	
Schedule of Benefits	**In-Network**	**Out-of-Network**
Deductible *(per calendar year)*		
Individual	N/A	N/A
Family	N/A	N/A
Coinsurance	0%	0%
Out-Of-Pocket Max. *(includes deductible, coinsurance, RX copays and RX coinsurance)*		
Individual	$5,500	N/A
Family	$11,000	N/A
Physician Services		
Preventive Care	Covered 100%	Not Covered
Primary Care Office Visits	$30 Copay	Not Covered
Specialist Office Visits	$60 Copay	Not Covered
Emergency Services		
Emergency Room Visit	$300 Copay	
Urgent Care	$50 Copay	Not Covered
Inpatient/Outpatient Services		
Inpatient Care	$750 per day for the first 5 days	Not Covered
Outpatient Surgery	Covered 100%	Not Covered
Diagnostic Lab / X-Ray	Covered 100%	Not Covered
High Tech Scans *(MRI, CT, etc.)*	Covered 100%	Not Covered
Physical/Occupational/Speech Therapy	$30 / $30 / $60	Not Covered

Prescription Drugs	Retail	Mail Order
Retail Preferred Specialty Non-Preferred Specialty	$10 / $45 / $70 / $50 Copay $50 Copay	Not Covered

Monthly Contributions	Employee Contribution	City Contribution
Employee Only	$130.06	$943.63
Employee + Spouse	$639.68	$1,886.78
Employee + Child(ren)	$639.68	$1,886.78
Employee + Family	$966.01	$1,863.23

Important Note!

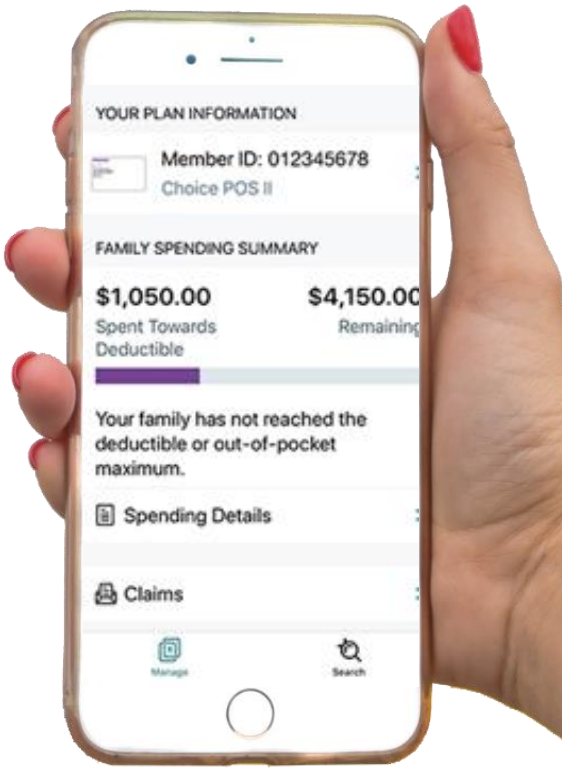
This plan includes a narrower network of providers. Be sure to confirm that your current providers are in-network before enrolling in this plan!

Rx BENEFITS

Prescription Drug Plan

The City of Belton's prescription drug plan is administered by Aetna.

Access online or download the Aetna mobile app shown on page 15 to begin quickly and efficiently accessing its benefits, including the ones below:



Maintenance Choice® Program

With this benefit, you have the freedom to decide where you fill the prescription drugs that you take on a regular basis – these are called maintenance medications.

- **Your Choice, Your Way**
  - Fill a 90-day supply of your maintenance drugs at a discounted rate. You can do this with our mail service pharmacy or at CVS Pharmacy® locations.
  - After two retail fills, you'll need to fill 90-day supplies with CVS Caremark Mail Service Pharmacy or at CVS Pharmacy stores.
- **How to Opt Out**
  - You can opt out of Maintenance Choice® for all your maintenance medications. Just let us know that you'd like to continue to fill your 30-day supply at your retail pharmacy.
  - When you do, you'll pay the regular retail copay for your 30-day supply. If we don't hear from you, you'll pay the full cost of your medications on the third fill.
  - Call Aetna anytime to opt out of the program and continue filling 30-day supplies:
    - 1-888-Rx Aetna (TTY: 771) or
    - 1-888-792-3862 (TTY: 711)

Enjoy the Convenience

Save time and money: You'll save time, and you can enjoy convenience of receiving your 90-day refills by mail. Since copays for 90-day refills are 2.5x the 30-day copay, you may also save money by receiving 90-day refills.

Have piece of mind: You'll have the medicines you need, when you need them.

Rx BENEFITS CONT.

Delivery Perks

- **CVS Caremark Mail Service Pharmacy:** Subscribe to the mail-order service and your prescription will arrive every 90 days.
- **CVS Pharmacy on-demand delivery:** Ask for 4-hour delivery within 10 miles of any CVS Pharmacy store, for a small fee *(some restrictions and caveats may apply)*.
- **CVS Pharmacy one- to two-day delivery:** Get free delivery within one to two days from the United States Postal Service *(some restrictions and caveats may apply).*

Let's Get Started!

- **If you're filling your prescription at a local CVS Pharmacy,** your pharmacist can change your prescription to 90-day refills.
- **If you're not filling your prescription at a CVS Pharmacy** and would like to switch to a mail service pharmacy:
    - Call Customer Care at 1-888-Rx-Aetna (TTY: 771) or 1-888-792-3862 (TTY: 711), or
    - Order Online. Visit the website that's on your member ID card, and then sign in to your account to submit your order.

CVS MINUTE CLINICS®

The Care You Need – In Person or Virtually

With your included MinuteClinic® benefit in your plan, healthier happens together. You get more options for where and when you get care. Plus, it's a lower-cost alternative to the emergency room or urgent care.

MinuteClinic Can Help You:

- **Get care 7 days a week,** including evenings so you can feel better faster.
- **Choose in-person and virtual care** options to easily access care your way.
- **Treat a variety of conditions, illnesses and injuries including:**
  - Asthma and allergies
  - Bronchitis and upper respiratory infections
  - Insect stings
  - Diabetes
  - Sore throats and ear infections
  - Minor cuts, blisters and wounds

Affordable Care, One-Stop Convenience

- **Find more than 1,150 MinuteClinic® locations** in 35 states and the District of Columbia.
- **Get virtual care.** At home or wherever you are, there's someone here to help.
- **$0 copay for members in copay-based plans, such as the PPO and EPO Plans.** Members with high-deductible health plans pay a discounted rate. After the deductible is met, there is no charge.
- **Book an appointment online or via our kiosks** within CVS store locations.
- **Get women's health care,** including prescriptions for contraceptives and other medications, when medically appropriate.

CVS HEALTH VIRTUAL PRIMARY CARE

From wellness visits to quick care, we've got you covered. Easily schedule a Virtual care appointment from anywhere. You can use CVS Health Virtual Primary Care in addition to your traditional network of providers. Access is included in your medical plan, made available through Aetna, a CVS Health company.

Teladoc doctors are U.S. board certified in Internal Medicine, Family Practice, Emergency Medicine or Pediatrics. They average 15 years practice experience and incorporate Teladoc into their day-to-day practice.

Get Started Today!

Scan the QR code or go to cvs.com/virtual-care

On-Demand Care

- Coughs, colds, flu and strep
- Joint, head, and stomach pain
- Infections (ear, sinus, skin, UTI)
- Medication refills

Mental Health Services

- Anxiety and mood disorders
- Depression screening
- Medication management
- Support with stress, life adjustments and conflict resolution
- Sleep and related health behaviors

Primary Care Service

- Chronic illnesses (asthma, diabetes)
- Sick care
- Wellness and annual health assessment
- Follow-ups from in-person visits
- Medication adjustments and refills

Some visits cost as low as zero dollars

Get coordination of in-person care, when needed, to nearby MinuteClinic locations** - or in-network provider clinics.

You get to choose your provider and enjoy flexible appointments that work with your busy lifestyle.

*Members enrolled in qualified high deductible health plans must meet their deductible before receiving covered non-preventive services at no cost share.

**MinuteClinic in-person services are not included with this product and are subject to plan benefit.

TELEMEDICINE

24/7 Healthcare Access

The City of Belton offers a telemedicine benefit through Teladoc to employees. This plan provides employees 24/7/365 access to healthcare services that is an affordable and convenient alternative to urgent care and emergency room visits.

Teladoc doctors are U.S. board certified in Internal Medicine, Family Practice, Emergency Medicine or Pediatrics. They average 15 years practice experience and incorporate Teladoc into their day-to-day practice.

What Can They Treat?

Teladoc doctors can treat many medical conditions, including:

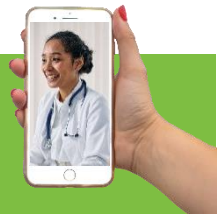
- Cold and flu symptoms
- Allergies
- Bronchitis
- Skin problems
- Respiratory infection
- Sinus problems
- And more!

When Can I Use It?

- When you need care now
- If your doctor is unavailable
- If you're considering the ER or Urgent Care Center for a non-emergency
- On vacation, a business trip, or away from home
- Short-term prescription refills

General Medical: $56 or less per visit

Mental Health: $90 or less per therapist visit



Talk to a doctor anytime, anywhere you happen to be

Receive quality care via phone or online video

Prompt treatment, average call back in 16 min

A network of doctors that can treat children of any age

Secure, personal and portable electronic health record (EHR)

No limit on consults, so take your time

How to Get Started

Setting up your account is quick and easy, so when you need care, a Teledoc doctor is just a call or click away.

1. Set Up Your Account:

- **Online:** Go to Teladoc.com/Aetna and "**set up account**"
- **Mobile App:** Download the app in the Google Play or App Store, and click "**Activate account**" or visit Teladochealth.com/start/mobile
- **Call Teladoc:** A representative can help you register your account over the phone. Call 1-855-TELADOC (835-2362)

2. Provide Medical History:

- It provides Teladoc doctors the information they need to make an accurate diagnosis

3. Request a Consult:

- Once your account is set up, request a consult any time.

TIPS FOR SMART HEALTHCARE

Help Control the Rising Costs

Everyone can play a role in controlling the rising cost of healthcare. City of Belton employees and covered family members have been doing a great job by using in-network doctors and hospitals and getting routine preventive care. It's important to continue these practices because making good choices leads to keeping the plan costs down.

Below are some ways that we can do our part in controlling the cost of healthcare.

1. Choose the Right Setting

Where you go for medical services can make a big difference in how much you pay and how long you wait to see a health care provider. The chart below can help you select the right setting for your needs:

	Telemedicine	Convenience Care Clinic	Urgent Care	Emergency Room	Your Doctor's Office
When to Use	• Cold or flu • Bronchitis • Respiratory infection • Sinus problems • Allergies • Urinary tract infection • Pediatric care • Poison ivy or pink eye	• Colds or flu • Sinus infections • Allergies Vaccinations or screenings • Minor sprains, burns or rashes • Headaches or sore throats	• Sprains / strains • Mild asthma attacks • Sore throats • Minor broken bones or cuts • Minor infections or rashes • Earaches	• Sudden change in vision, weakness or trouble talking • Large, open wounds • Difficulty breathing • Severe head injury • Heavy bleeding • Spinal injuries • Chest pain • Major burns • Major broken Bones	• Preventive services and vaccinations • Medical problems or symptoms that are not an immediate, serious threat to your health or life
Approx. Wait Time	15 minutes	15 minutes	20 – 30 minutes	1 – 3 hours	1 week

2. Stay In-Network

Seeing in-network doctors saves you money because the providers have agreed to drastically discount their usual fees, but the benefits are better too!

3. Stay Healthy

All City of Belton health plans cover Routine Preventive services at 100% in-network which includes physical exams, vaccines, blood tests and cancer screenings. These services can prevent you from getting sick or detect a health issue before it gets serious.

FIND A PROVIDER

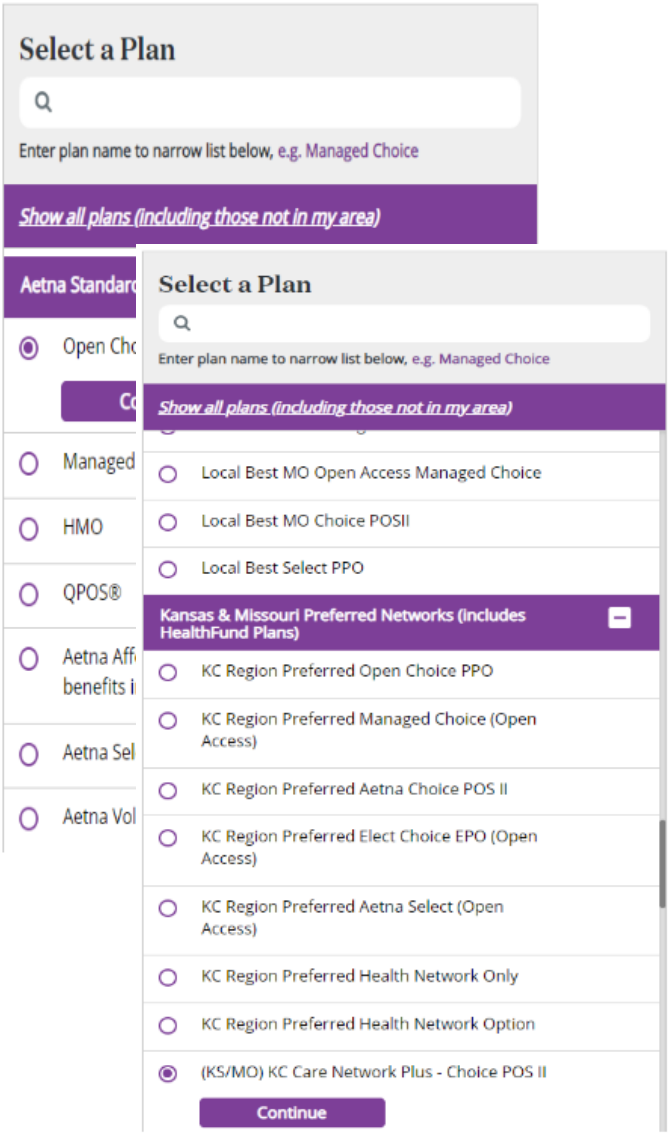
Aetna Provider Search

It's important to use in-network providers to save both you and the health plan money! Follow the instructions below to find a new in-network provider or to determine if your current providers are in-network.

Medical Plans:

Visit www.aetna.com/docfind

- Under **Continue as guest** enter your zip code, city, state or county then click Search.
- Next, choose the appropriate plan from the **Select a Plan** drop down menu.
    - *For the HDHP and PPO Plans:* Under **Aetna Standard Plans** choose **Open Choice PPO** and click Continue
    - *For the EPO Plan: Under* **Kansas & Missouri Preferred Networks** choose **(KS/MO) KC Care Network Plus – Choice POS II**
- Input in the provider's name or the type of provider for which you are searching (examples include primary care physicians or urgent care)



Prescription Drugs:

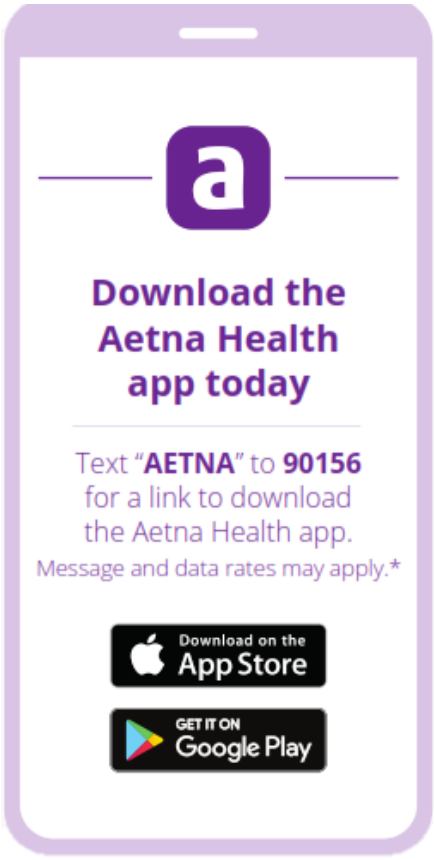
Visit www.aetna.com

- Click on **Find a Medication** at the top of the screen.
- Enter **2025** in the **Plan Year** drop down and **Advance Control Plans – Aetna** in the **Choose a Plan** drop down, then click **View Pharmacy Plans**
- Click **Find a Covered Drug** and search for your prescription to check its status

AETNA MOBILE APP

Features of the Mobile App

- **Find a doctor –** it's easy to search for doctors, dentists and specialists in your area.
- **Message center –** one location for all Aetna email correspondence from Member Services.
- **Check benefits and coverage information –** just clear, accurate details when you click.
- **Pharmacy –** find a pharmacy, get drug costs, or refill a prescription on the go.
- **Member payment estimator –** real time estimates for out-of-pocket medical expenses based on your health plan.
- **Look up symptoms on the iTriage app –** it's easy to search symptoms, conditions and medicine.
- **Search claims –** no more guesswork when you don't have the paperwork with you.
- **Pull up your medical and/or dental ID card information –** if you left your ID card at home, it's no problem.



How do I get started?

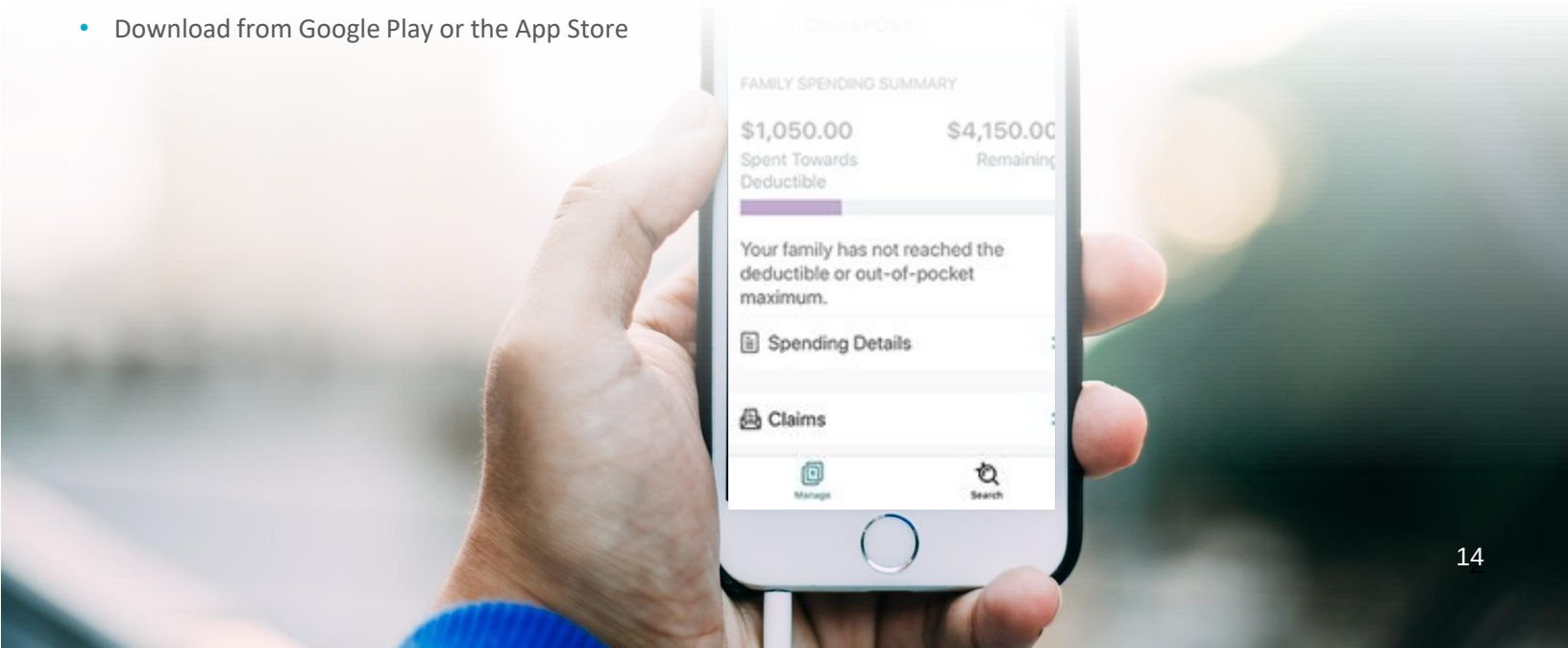
To use the app, you have to be registered for your secure member website.

Visit MyAetnaWebsite.com and select register.

Download the app:

There are two ways to download the app:

- Text AETNA to 90156 (data and messaging rates may apply)
- Download from Google Play or the App Store



HEALTH SAVINGS ACCOUNT (HSA)

How Does an HSA Work?

If you enroll in the HDHP, you may contribute to your Health Savings account through payroll deductions on a pre-tax basis. Annual maximum contribution limits are set each year by the IRS and are illustrated below. For 2025, if you have single coverage your maximum contribution is $4,300. If you cover a Spouse and/or Children, your maximum contribution is $8,550.

UMB Count on more.

For HSA accountholders aged 55 and older, an additional $1,000 annual “catch up" contribution is allowed each year.

The City of Belton will contribute $87.79 per month to your HSA if you are enrolled in Employee Only coverage on the HDHP.

How Do I Use the Funds?

Using your HSA funds is easy. The UMB HSA debit card conveniently allows you to pay for eligible expenses using the funds in your HSA. Your HSA funds don’t just benefit you. You can use the funds for your spouse and tax dependents for their eligible expenses too – even if they’re not covered by your medical plan. Eligible expenses are determined by the IRS, and it is your responsibility to ensure you use the funds for eligible items. The IRS also requires you to keep your receipts for up to 5 years in the event you are audited.

Important Notes!

Contribution changes can always be made in Employee Navigator.

Unlike a Flexible Spending Account, the funds in your HSA rollover every year.

Who is Eligible to Participate in the HSA?

- You must be covered under a Qualified High Deductible Health Plan, like the one offered by the City.
- You cannot establish an HSA if you or your spouse also have a Medical FSA.
- You cannot be enrolled in Medicare or TRICARE due to age or disability.
- You cannot set up an HSA if you have insurance coverage under another plan, such as your spouse’s employer, unless that secondary coverage is also a Qualified High Deductible Health Plan.
- You cannot be claimed as a dependent under someone else’s tax return.

FLEXIBLE SPENDING ACCOUNT (FSA)

How Does an FSA Work?

The City of Belton offers employees enrolled in the PPO or EPO Plans the opportunity to participate in the Flexible Spending Plan administered by BASIC.

A Flexible Spending Account (FSA) is an account in which you set aside pre-tax dollars to pay for eligible health care or dependent care expenses not covered by insurance.

The annual amount you elect to contribute to each account will be divided into equal amounts and deducted from your paycheck pre-tax. Funds can be used for expenses incurred from January 1, 2025 through March 15, 2026 (a total of 14.5 months). You have until March 31, 2026, to submit claims and receipts for reimbursements from the 2025 plan year. Unused funds left in the account(s) from the previous year that are not used to reimburse expenses incurred by the end of the plan year are subject to the use-it-or-lose-it rule and are forfeited.

By setting aside pre-tax dollars to pay for out-of-pocket expenses you would normally pay for using after-tax dollars, you are reducing your "taxable income" because it reduces the amount of federal, state and FICA taxes you pay. **This means more take-home pay for you!**

Healthcare FSA

You may elect an amount up to $3,300 per plan year to be used for medical, prescription, drug, dental and vision expenses for you and eligible dependents. Funds can be used for expenses incurred from January 1, 2025 - March 15, 2026.

Dependent Care FSA

The City offers a Dependent Care FSA (max contribution of $5,000 per year or $2,500 per year if married and filing separate tax return), which is a pre-tax benefit account used to pay for eligible dependent care services, such as preschool, summer day camp, before or after school, and child or adult daycare.

How Do I Use the Funds?

1. You can use the BASIC debit card instead of your own cash or credit cards to pay for eligible expenses. When you use it, the amount of the expense is deducted from your account balance at the point of sale.
2. You can pay for your expenses up front using your own cash or credit cards and reimburse yourself by submitting a claim form. Completed claim forms and itemized receipts can be submitted online at www.basiconline.com/hq.

Eligible Expenses Examples for Healthcare FSA:

- Coinsurance & Copayments
- Contraceptives
- Crutches
- Dental expenses
- Dentures
- Diagnostic expenses
- Eyeglasses
- Handicapped Care
- Hearing devices and batteries
- Hospital bills
- Deductible amounts
- Orthodontia
- Prescription drugs
- Psychologist expenses
- Oxygen
- Laboratory fees

Contact BASIC: Call **(800) 372-3539 ext. 6270** or log on to **www.basiconline.com/hq**.

DENTAL BENEFITS

About Your Dental Plan

The City of Belton offers a dental plan through Aetna utilizing the Dental PPO/PDN with PPO II Extended Network. You may use the dental provider of your choice; however, you will receive greater benefits by seeing an Aetna participating network provider. Aetna network providers have agreed to considerably discount their services, so you pay less out of pocket. If you see a Non-Participating provider, your out-of-pocket expenses may be much greater because you would not be receiving the discounts that Participating network providers offer. Also, if you go out of network the non-network dentist may balance bill you for the difference between Aetna's accepted fee and the provider's actual charge.

To search for a Participating network provider, go to **aetna.com/docfind** and search the Dental PPO/PDN with PPO II and Extended Network.

Dental Plan Design		
Calendar Year Deductible	**In-Network**	**Out-Of-Network**
Individual / Family	$50 / $150 *(applies to Basic & Major services)*	
Calendar Year Maximum	$1,250 *(applies to Preventive, Basic & Major services)*	
Class I - Preventive & Diagnostic Services		
Oral Evaluations, Cleanings, X-Rays, Fluoride Treatments, Sealants	100%	100%
Class II - Basic Services		
Fillings, Endodontics, Periodontics, Simple & Surgical Extractions	90%	80%
Class III - Major Services		
Oral Surgery (except for extractions covered under Basic), Prosthetics: bridges & dentures, Crowns, Jackets, Veneers, Inlays, Onlays	60%	50%
Orthodontia (Adult & Children)		
Diagnostics & Treatment	50% up to the $1,250 lifetime maximum	

The entire cost of your Dental Insurance is paid for by the City of Belton, regardless of which coverage tier you elect!

VISION BENEFITS

About Your Vision Plan

The City of Belton offers a comprehensive vision plan through Aetna. You may use the vision provider of your choice; however, you will receive much greater benefits by seeing an Aetna Vision Preferred Network provider. To search for a network provider, please visit Aetna's website at **www.aetna.com/docfind**.

Vision Plan Design		
	In-Network	Out-of-Network
Exam Copay	$10 copay	Up to $25 retail
Frequency (based on date of service)		
Exam	Every 12 months	
Lenses	Every 12 months	
Frames	Every 24 months	
Lenses		
Single	$10 copay; 100% covered	Up to $20 retail
Bifocal	$10 copay; 100% covered	Up to $40 Retail
Trifocal	$10 copay; 100% covered	Up to $65 Retail
Standard Progressive Lenses	$75 copay; up to $120 reimbursement	Up to $40 Retail
Contact Lenses (instead of eyeglass lenses)		
Fitting Fee	$0 copay	N/A
Contact Lenses	Up to $130 Retail	Up to $90 Retail

The entire cost of your Vision Insurance is paid for by the City of Belton, regardless of which coverage tier you elect!

Special Promotions for All Members:

To use these benefits, just show the provider you have Aetna Vision insurance.

- $50 off purchase at CVS Optical
- Up to $25 off Transitions lenses
- $25 off purchase at Lens Crafters
- $20 off any purchase or $50 off any purchase of $200 or more at SUNGLASS HUT
- $25 off at Target Optical
- $25 off at Pearle Vision
- Up to $20 off at contactsDirect.com
- 15% off retail prices or 5% off promotional prices on LASIK or PRK from US Laser Network

LIFE INSURANCE

Company-Paid & No Cost to You

If others depend on you for financial support, part of your financial plan should include how you will provide for them in the event of your death.

The City of Belton provides life insurance coverage for you at no cost. Basic Life Insurance pays a benefit in the event of a death, while Accidental Death & Dismemberment Insurance provides an additional benefit to you or your beneficiaries in the event of an accidental death or other covered loss.

- **Employee:** Basic Life and AD&D coverage is equal to 1.5 times your annual salary up to a maximum of $250,000. Your coverage will decrease by 35% when you turn age 65, and an additional 15% reduction at age 70. Note: The IRS requires you to be taxed on the value of employer-provided group term life insurance over $50,000. The taxable value is called "imputed income" and will be included in your taxable income on your Form W-2.

Voluntary Life / AD&D Insurance

You may purchase Voluntary Life/AD&D insurance for yourself, your spouse and/or your dependent children. In order to purchase coverage for your spouse and/or children, you must also elect coverage for yourself.

- **Employee:** You may purchase coverage in increments of $10,000 up to a maximum of $500,000, not to exceed 5 times your annual earnings. The guaranteed issue amount is $120,000. Employee coverage will reduce by 35% at age 65, and by an additional 15% at age 70.
- **Spouse:** You may purchase coverage for your spouse in increments of $5,000 up to a maximum of $250,000, not to exceed 100 percent of Employee coverage amount. You must purchase Employee Voluntary Life/AD&D coverage in order to elect Spouse coverage. The Spouse guarantee issue amount is $30,000. Spouse coverage will reduce by 35% when the spouse turns age 65, and by an additional 15% at age 70.
- **Children:** You may purchase coverage for your dependent child(ren) who are under age 26 in $2,500 increments up to a maximum of $10,000. You must purchase Employee Voluntary Life/AD&D coverage in order to elect Child coverage. Coverage does not require a health questionnaire.

If you or your spouse are electing coverage that exceeds the Guarantee Issue amount, you will need to submit an Evidence of Insurability (EOI) form to be medically underwritten and approved by USAble.

Evidence of Insurability: If you wish to newly purchase Voluntary Life / AD&D insurance, or you wish to increase your current Voluntary Life / AD&D insurance amount, you will be required to submit an Evidence of Insurability (EOI) form to be medically underwritten and approved by USAble.

DISABILITY INSURANCE

About Our Disability Coverage

Disability insurance provides some income replacement should you become disabled and unable to work due to a non-work-related injury or illness. A disability can occur at any time. If the disability is severe enough, it will prevent you from being able to work and provide for your family. That is why The City of Belton provides Long-term Disability insurance at **no cost to employees**. Eligible employees are automatically enrolled.

Long-term Disability

You may qualify for Long-term Disability if you are unable to work due to a qualifying injury or illness for 90 days or more. This plan provides 60% income replacement up to a maximum of $7,000 per month until your Social Security Normal Retirement Age. Any illness or injury for which you received treatment during the first 3 months prior to your effective date of coverage will be excluded during the first 12 months you are enrolled in the plan. Because the LTD premium is company paid, the benefit paid to the employee will be taxable.

For more specific details, limitations and exclusions please refer to the Plan Documents located in Employee Navigator.

Could you pay the bills if you weren't working?

- Less than **1/4** of U.S. consumers have enough emergency savings to cover six months or more of their expenses.
- Nearly **70%** of workers that apply for Social Security Disability Insurance **are denied**.
- Nearly **40 million** American adults live with a disability.

VOLUNTARY ACCIDENT INSURANCE

MetLife

How Do I Use This Benefit?

Even with health insurance, an accidental injury can cost you thousands of dollars. Lost wages from missing work, health insurance deductibles and daily living expenses can create long-term financial problems.

Accident insurance helps cover the added costs that you may face following a bad injury.

What Does This Benefit Cover?

This plan covers several injuries and services.

The chart to the right shows a short list of injuries and services that may qualify for a benefit payment.

What Are the Two Plan Options?

This plan covers offers Employees two options: the Low Plan and the High Plan. The Low Plan will pay a slightly lower benefit, while the High Plan offers higher payouts.

Benefit Amounts Per Accident (Low Plan / High Plan)	
Ambulance - Ground	$300 / $400
Ambulance - Air	$1,000 / $1,250
Emergency Room Treatment	$150 / $200
Initial Hospital Admission (non-ICU)	$1,000 / $1,500
Major Diagnostic Exam	$150 / $200
Dislocation Maximum Benefit	$8,000 / $10,000
Fracture Maximum Benefit	$8,000 / $10,000
Laceration Maximum Benefit	$400 / $700
Coma	$7,500 / $10,000
Organized Sport	additional 25% of benefit amount
Accidental Death & Dismemberment	
Death Benefit Amounts	**Low Plan -** Employee: $25,000 / Spouse: $12,500 / Child $5,000 **High Plan -** Employee: $50,000 / Spouse: $25,000 / Child $10,000
Catastrophic Loss	Quadriplegia: 80% of AD&D / Hemiplegia or Paraplegia: 40% of AD&D Loss of Speech and Hearing (both ears): 80% of AD&D
Dismemberment	Hand or Foot or Sight: 15% of benefit amount Loss of 2 or more fingers/toes: 5% of benefit amount
Contract Features	
Portability	Included; you can take the coverage with you if your employment terminates

Employee Contribution *(per month)*		
Coverage Tier	**Low Plan**	**High Plan**
Employee Only	$8.81	$13.15
Employee + Spouse	$17.33	$25.73
Employee + Child(ren)	$20.84	$30.78
Employee + Spouse/Child(ren)	$24.59	$36.36

VOLUNTARY CRITICAL ILLNESS INSURANCE

How Do I Use This Benefit?

Critical illness benefits pay a lump-sum benefit directly to you upon first or second diagnosis of a covered critical illness. This chart below shows a small sample of the conditions covered under this plan.

Benefit Amounts		
Employee	You may elect a lump sum Benefit Amount of $15,000 or $30,000	
Spouse	Coverage will be offered at 50% of the Employee Benefit Amount	
Child (up to age 26)	Coverage will be offered at 50% of the Employee Benefit Amount	
Conditions	**Initial Benefit** *(% of benefit amount)*	**Recurrence Benefit** *(% of initial benefit)*
Invasive Cancer	100%	100%
Non-Invasive Cancer	25%	100%
Kidney Failure	100%	None
Major Organ Transplant	100%	None
Heart Attack	100%	100%
Stroke	100%	100%
Coma	100%	100%
Paralysis	100%	None
Alzheimer's Disease	100%	None
Contract Features		
Portability	Included; you can take the coverage with you if your employment terminates	
Health Screening Benefit	$50 benefit payable if an eligible covered person takes an eligible screening/prevention measure. The benefit is payable once per year for each covered Employee, Spouse, and Dependent Child.	
Pre-Existing Condition Limitation	None	

Employee Contribution per $1,000 *(per month)*				
Age	**Employee Only**	**Employee + Spouse**	**Employee + Child(ren)**	**Employee + Spouse/Child(ren)**
<25	$0.42	$0.68	$0.61	$0.87
25-29	$0.49	$0.80	$0.68	$0.98
30-34	$0.62	$0.98	$0.80	$1.17
35-39	$0.83	$1.32	$1.02	$1.51
40-44	$1.16	$1.83	$1.35	$2.02
45-49	$1.66	$2.56	$1.85	$2.75
50-54	$2.29	$3.45	$2.48	$3.64
55-59	$3.32	$4.88	$3.51	$5.07
60-64	$4.50	$6.54	$4.69	$6.73
65-69	$6.08	$8.75	$6.27	$8.94
70-74	$8.03	$11.58	$8.22	$11.76
75+	$11.03	$16.12	$11.22	$16.31

Note – Premium amounts will be calculated for you when enrolling in Employee Navigator.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The City of Belton understands the challenges life can throw your way, which is why we partnered with SupportLinc. The EAP can enhance your wellbeing at any stage of life and assist you in being a better parent, grandparent, friend or spouse/partner; achieving life balance, planning for the future, becoming happier and more resilient, overcoming addictions, solving legal and financial challenges, and so much more.

A wide array of **confidential** counseling and life coaching services are available **at no cost to you and your family 24/7.**

The EAP Helps With Life's Challenges

EAP can provide services to you and your family members, including:

- Counseling Services (up to 6-sessions per issue)
- Consultations: Financial, Legal, Parenting, and more
- Education Planning
- Adult and Childcare Resources
- Health Coaching and Life Coaching
- Retirement Coaching
- Tobacco Cessation Coaching

SupportLinc:

(888) 881-5462
www.supportlinc.com
Group Code: belton

Digital Behavior Health Program

The Animo program, offered in conjunction with the SupportLinc EAP, provides web and mobile tools that help users address stress, depression, or anxiety. This includes resources for coping with panic, breathing, mindfulness, problem solving and more.

Animo is safe and secure – just for you. Discover your inner strength today by visiting the Animo portal, downloading the Animo App, clicking on the Animo tile in the Be Well Portal, or you can access it through the SupportLinc website.

Animo:

www.goanimo.com

MISSOURI LAGERS BENEFITS

Understanding your LAGERS Benefits

You start earning service on the first day of full-time employment. Keep in mind, you must work **1,500** hours per year to be eligible.

Once you have worked 5 years (60 months) with any LAGERS employer, you are guaranteed to receive a benefit. The City of Belton fully funds your benefit. You pay 0% employee contribution.

Your LAGERS benefit is based on your highest consecutive **36-month** average salary in the last 120 months of credited service. The more you earn, and the longer you work, the larger your retirement benefit.

When you reach retirement, you will reap the fruits of your labor with secure income through your retirement years.

- *Normal Retirement Age:*
  - General = 60
  - Police & Fire = 55
- *Early Retirement Age:*
  - General = 55
  - Police & Fire = 50

Disability & Survivor Benefits

If you have worked for a LAGERS employer for more than 60 months (5 years), you are eligible for disability and survivor benefits, and if you have not worked that long, you will still be eligible if the cause of disability or death is duty-related. You can find more information about your disability and survivor benefits in the member handbook.

Benefits at a Glance:

- Eligibility: 5 years of service, 1,500 hours annually
- Program Multiplier: 2.00% (L-6)
- Final Average Salary: 3 years
- Contributions: 0% employee contribution
- Retirement Age: Normal retirement age

Contact Us:

- info@molagers.org
- 1-800-447-4434
- www.molagers.org
- Blog.molagers.org

457(b) DEFERRED COMPENSATION PLAN

About the 457(b) Plan

The City of Belton offers two 457(b) deferred compensation plans, one is administered by Mission Square Retirement and the other is Nationwide. Please note that these plans are NOT administered through Employee Navigator. The 457(b) plans are available to all full-time employees, and you are eligible immediately upon hire.

You can decide the amount to contribute and can start, stop, or change your contribution amount at any time. You can elect to make pre-tax or post-tax contributions and may also transfer, or roll over, other eligible retirement accounts to the plan. The IRS limits contributions. The IRS limits for 2025 are shown below.

Plan	Normal Limit	"Age 50" Catch-up Limit	"Pre-Retirement" Catch-Up Limit
457(b)	$23,000	$7,500	$23,000

You are always 100% vested in your own contributions and earnings! Your contributions will be invested in the funds that you select, and the value of your account will fluctuate based on the performance of the funds. Carefully review your investment options before making your selections. You can make changes to your investments at any time.

Roth Option

Employees have the option to contribute towards a Roth plan. Under a Roth plan, contributions are made after-tax. When taking withdrawals in retirement, distributions are tax-free, subject to specific IRS rules.

Withdrawals and Loans

After you separate from service with your employer, you will be eligible to withdraw your money at any time, however, you will not be required to take any withdrawals until after age 73. While you are still employed, your withdrawal options are limited to attaining age 70 ½, balances under $5,000 (with no contributions made for a period of two years), or emergency withdrawals, as defined by the IRS.

Your plan allows you to borrow money from your account while you are still employed. The maximum load amount is limited to half of your account balance or $50,000, whichever is less.

Post-Retirement Public Safety Officer Benefit

This benefit allows those who retire in Public Safety the ability to withdraw $3,000 tax-free to go towards health insurance premiums.

Questions?

If you have questions about the 457(b) plans, please reach out to Donna Greener at dgreener@belton.org or (816) 892-1251.

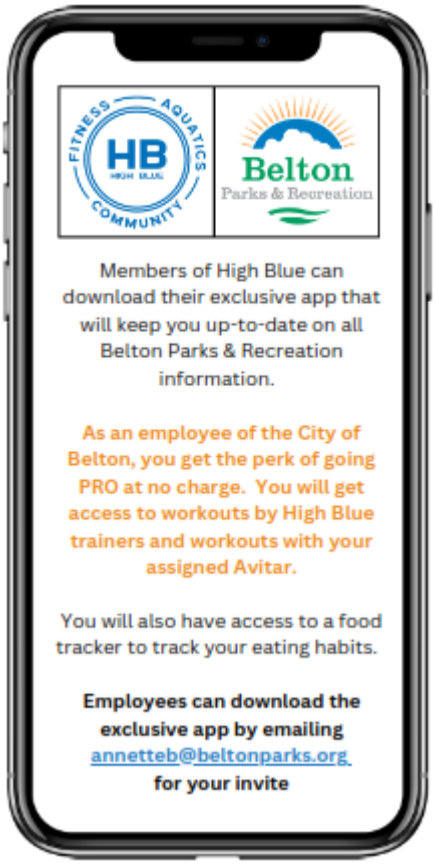
HIGH BLUE WELLNESS CENTER

High Blue Wellness Center

Employees are able to enjoy a FREE membership at High Blue, through Belton Parks & Recreation. Families include an employee and their dependents up to age 23. Dependents age 19-23 will have to provide documentation of their student status to be eligible.

Amenities Include:

- Group fitness classes (i.e., Zumba, yoga, Pilates, water aerobics, spin & more)
- Cardio equipment
- Kids' classes
- Free weights
- Gymnasium (with scheduled activities including basketball, volleyball and pickle ball)
    - Check the schedule at www.beltonparks.org/180/schedules
- Garage gym
- Use of the zero-entry recreation pool, lazy river, and two recreation slides and use of the six-lane competition pool
- Sauna
- Kid's corner (for an additional cost)



For an additional fee you can participate in small group training or personal training.

To take a tour or to learn more information about High Blue, simply stop by the front counter, at 16400 N Mullen Road, visit www.beltonparks.org/27/High-Blue or contact Shanna Beltz at shannab@beltonparks.org.

INSURANCE TERMS & GLOSSARY

Coinsurance:

The designated portion of the approved amount you are required to pay for covered services. This amount is typically a percentage of the service cost.

Copay:

A copay is the amount you pay for covered services when you or a covered dependent visits a doctor's office or purchase a prescription drug. Medical and prescription drug copays do not apply toward your deductible but do apply toward your annual out-of-pocket maximum.

Deductible:

A deductible is the amount you are responsible to pay for services such as doctor's visits, prescription drugs, inpatient hospital stays, outpatient surgery, and high-tech scans before the Plan begins to pay.

If you elect to cover any dependents, you will want to know how your Family Deductible works. This is important because it determines what you must pay out-of-pocket before the Plan begins to pay. Our Plan has an **Embedded Deductible.** Be sure to review the definition for Embedded Deductible to better understand how our plan works.

Dependent Care FSA:

Pre-tax benefit account used to pay for eligible dependent care services, such as preschool, summer day camp, before or after school programs, and child or adult daycare.

Eligible Medical Expenses:

Expenses that you are allowed to spend money on, as specified by the medical plan. Specific treatments and medication may qualify as eligible medical expenses, whereas rent or groceries would not. This term is commonly associated with health savings accounts.

Embedded Deductible:

Under an embedded deductible, the single deductible is embedded in the family deductible, so no one family member can contribute more than the single amount towards the family deductible. Once the member meets their single deductible, they will start paying copays and coinsurance toward the out-of-pocket maximum.

Evidence of Insurability (EOI):

Record of a person's past and current health events. It's used by insurance companies to verify whether a person meets the definition of good health.

Flexible Spending Account (FSA):

Is an account in which you set aside pre-tax dollars to pay for eligible health care or dependent care expenses not covered by insurance. The annual amount you elect to contribute to each account will be divided into equal amounts and deducted from your paycheck pre-tax.

Guaranteed Issue:

The amount of life insurance available to an employee without having to provide Evidence of Insurability, or EOI.

Health Savings Account (HSA):

This is an individually-owned, tax-advantaged account used to pay for eligible out-of-pocket health care expenses (i.e., medical, dental, vision, prescription drug). In order to participate, you must be enrolled in a Qualified High Deductible Health Plan (QHDHP) like The City's HDHP plan. You cannot contribute to an HSA if you are covered by a non-QHDHP such as a PPO plan with copays, covered by Medicare or Tricare, or covered as a dependent on another person's tax return.

Health Savings Account (HSA) Catch-Up Contributions:

Employees 55 and older enrolled in the HSA may contribute an additional amount to the annual maximum. These contributions must end when the individual enrolls in Medicare.

High Deductible Health Plan (HDHP):

A type of health plan that has lower monthly premiums, but higher deductibles and out-of-pocket limits, than a traditional health plan. HDHPs require members to satisfy the deductible prior to the plan applying the coinsurance benefit. HDHPs are often coupled with an HSA.

In-Network Provider:

In-Network providers are doctors and/or facilities who are contracted with the insurance company. In-network providers must accept the amount paid by the plan.

INSURANCE TERMS & GLOSSARY CONT.

Limited-Purpose Health Care FSA:

This plan is for those enrolled in the HDHP plan (with an HSA) and can only be used for non-medical expenses such as dental, vision, and orthodontia expenses.

Out-of-Pocket Maximum:

Every calendar year you have an Out-of-Pocket Maximum, which is the maximum amount you will pay out-of-pocket for covered medical services. It includes the deductible, coinsurance, medical copays, and prescription drug copays. Charges for non-covered services, non-compliance penalties and charges in excess of Aetna's negotiated fees do not count toward the Out-of-Pocket Maximum. Once the annual Out-of-Pocket Maximum has been reached, the Plan will pay 100 percent for covered services.

Preferred Provider Organization (PPO) Plans:

Plans that allow you to choose any provider, in or out-of-network. Discounts are greater when choosing in-network providers.

Premium:

The amount you pay for a health plan in exchange for coverage. This is sometimes shown as a per-paycheck, monthly, or annual amount, so pay attention to how it's written in your benefits descriptions.

Qualifying Event:

Circumstances that can significantly impact your personal and financial situation—such as getting married, divorced, having a baby or adopting a child, and the death of a spouse. Changes must be made within 30 days of the qualifying event. If changes are not made during that time, you must wait until the next open enrollment period to change your benefits. To make a change, submit the qualifying event through Employee Navigator. Contact Human Resources if you have questions.

CONTACT INFORMATION

Benefit	Vendor	Phone Number	Website/Email
Medical	Aetna Network: **HDHP & PPO:** Open Choice PPO **EPO:** (KS/MO) KC Care Network Plus – Choice PPO II Network	1 (800) 872-3862	www.aetna.com
Prescription Drugs	Aetna Formulary: Advanced Control Formulary Aetna Insured	1 (800) 872-3862	www.aetna.com
Telemedicine	Teladoc	1 (855) TELADOC (835-2362)	www.Teladoc.com/Aetna
Dental	Aetna Network: Dental PPO/PDN with PPO II and Extended	1 (800) 872-3862	www.aetna.com
Vision	Aetna Network: Aetna Vision Preferred	1 (800) 872-3862	www.aetna.com
Health Savings Account	UMB	(816) 474-4472	www.umb.com
Flexible Spending Account	BASIC Health, Dependent Care FSA	(800) 372-3539 ext. 6270	www.basiconline.com/hq/
Life & Disability	USAble Life	(800) 370-5856	www.usablelife.com
Employee Assistance Program	SupportLinc	(888) 881-LINC (5462)	www.supportlinc.com Login code: belton
457(b) Plan	MissionSquare Retirement	(202) 759-7053	**Mission Square:** jahoffman@missionsq.org Retirement Specialist: Jake Hoffman **Nationwide:** sunderw@nationwide.com OR (888) 401-5272 Retirement Specialist: Wade Sundermann
Wellness Center	High Blue Wellness Center	(816) 348-7400	www.beltonparks.org/27/High-Blue
Supplemental Health	MetLife	1 (800) GET-MET8 (1-800-438-388)	www.mybenefits.metlife.com
Missouri LAGERS	Missouri LAGERS	1 (800) 447-4434	info@molagers.org www.molagers.org

LEGAL NOTICES

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 calendar days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage.) ***This Special Enrollment opportunity is available only if you indicated (or otherwise as required) information regarding your or your dependents' other coverage on your initial enrollment form/waiver.***

In addition, if you acquire 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.

You may also be eligible for a Special Enrollment Period if you and/or your dependents are determined to be eligible for premium assistance under a state Medicaid plan or state child health plan. You must request enrollment within 60 days of the date you are determined to be eligible for this premium assistance.

Continuation of Group Health Plan Coverage (COBRA)

COBRA continuation coverage is a continuation of medical, dental and vision plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". If medical, dental or vision coverage for you or your eligible family members ceases because of certain "qualifying events" specified in COBRA (such as termination of employment, reduction in hours, divorce, death or a child ceasing to meet the definition of "dependent"), then you and your eligible family members may have the right to purchase continuation coverage for a temporary period of time. COBRA rights are explained in detail in the insurance booklet. You or your dependent will have to pay for this coverage. If you have any questions about your COBRA rights, please contact the Plan Administrator for a copy of your COBRA rights.

Mental Health Parity & Addiction Act

The Mental Health Parity and Addiction Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For more Information regarding the criteria for medical necessity determinations made under your employer's plan with respect to mental health or substance use disorder benefits, please contact your plan administrator.

Michelle's Law

When a dependent child loses student status for purposes of the group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the group health plan, whichever is earlier.

For additional information, contact your plan administrator.

Uniformed Services Employment and Re-Employment Rights Act of 1994

The Uniformed and Services Employment and Re-Employment rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life or Accidental Death & Dismemberment coverage you may have. A full explanation of USERRA and your rights is beyond the scope of this document. If you want to know more, please see the Summary Plan Description (SPD) for any of our group insurance coverage or go to this site: http://www.dol.gov/vets/programs/userra/main.htm

An alternative source is VETS. You can contact them at 1-866-4-USA-DOL or visit this site: http;//www.dol.gov/vets
An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm

LEGAL NOTICES

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Since 2014, there is now a new way to buy health insurance: the **Health Insurance Marketplace**. To assist you with evaluating the options for you and your family, this notice provides some basic information about the new Marketplace.

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 for coverage purchased through the Marketplace. Open enrollment for health insurance coverage through the Marketplace begins in October for coverage starting as early as January 1st.

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 9.86% 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 usually excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace would be made on an after-tax basis.*

How Can I Get More Information on my Employer's Health Coverage?

Please read the next page for more information you'll need if you decide to shop for coverage on the Marketplace. For additional information about your employer-sponsored health coverage, please contact Human Resources.

How Can I Get More Information on the Marketplace?

The Marketplace will consist of state-specific websites where you can compare health insurance options available where you live. Some states have created their own Marketplace, while others will be using sites run by the U.S. Department of Health and Human Services. Please visit **HealthCare.gov** or call **800-318-2596** for more information and to obtain contact information for a Health Insurance Marketplace in your state.

Employer Name: City of Belton	Employer ID Number (EIN)	Employer Phone Number: (816) 331-4331 x2108
Employer Street Address: 506 Main Street	City, State: Belton, MO	Zip: 64012
Who May be contacted about employer health coverage at this job? Donna Greener		Email Address: dgreener@belton.org

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's some of the employer information you will be asked to provide when you visit HealthCare.gov:

- City of Belton offers an employer-sponsored health plan to full-time employees working at least 30 hours per week.
- The coverage under The City of Belton's health plan meets the minimum value standard and is considered "affordable" under the Affordable Care Act.

For more information about the Health Insurance Marketplace in your state, visit **HealthCare.gov** or call **800-318-2596**.

LEGAL NOTICES

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following states are current as of July 31, 2024. Contact your state for more information on eligibility –

ALABAMA - Medicaid	ALASKA - Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS - Medicaid	**CALIFORNIA - Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA - Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA - Medicaid	**INDIANA - Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA - Medicaid and CHIP (Hawki)	**KANSAS - Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660

LEGAL NOTICES

KENTUCKY - Medicaid	LOUISIANA - Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE - Medicaid	**MASSACHUSETTS - Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA - Medicaid	**MISSOURI - Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA - Medicaid	**NEBRASKA - Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA - Medicaid	**NEW HAMPSHIRE - Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY - Medicaid and CHIP	**NEW YORK - Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA - Medicaid	**NORTH DAKOTA - Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA - Medicaid and CHIP	**OREGON - Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA - Medicaid and CHIP	**RHODE ISLAND - Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA - Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS - Medicaid	**UTAH - Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT- Medicaid	**VIRGINIA - Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924

LEGAL NOTICES

WASHINGTON - Medicaid	WEST VIRGINIA - Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN - Medicaid and CHIP	**WYOMING - Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Women's Health and Cancer Rights Act

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

1. All states of reconstruction of the breast on which the mastectomy was performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications during all states of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductible, copays, and coinsurance applicable to other medical and surgical benefits under the plan.

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).

Notice of Availability of HIPAA Privacy Notice

Under the Health Insurance Portability and Accountability Act (HIPAA), health plans are required to provide covered individuals with a Privacy Notice that describes, among other things, the uses and disclosures of protected health information that may be received by the plans, your rights regarding that information and the plans' responsibilities.

HIPAA requires we advise you that a copy of the Privacy Notice is available by contacting Human Resources and requesting a hard copy.

LEGAL NOTICES

Drug Coverage and Medicare

The Medicare Modernization Act requires The City of Belton to provide creditable coverage notices to all of the Medicare-eligible members of our health plan who have prescription drug coverage. This notice is provided to help employees decide whether to enroll in a Medicare Prescription Drug plan or to continue with prescription drug coverage offered by The City of Belton. A copy of the complete notice may be requested through the Human Resources Department.

Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008 protects employees against discrimination based on their genetic information. Unless otherwise permitted, your employer may not request or require any genetic information from you or your family members.

GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law.

To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA, includes an individual's family medical history, the results of genetic tests, the fact that a member sought or received genetic services, and genetic information

Important Notice from The City of Belton 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 The City of Belton 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. 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. UMR has determined that the prescription drug coverage offered by The City of Belton 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 through 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 (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current UMR coverage will not be affected. Your current coverage pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan. If you drop your coverage with UMR and enroll in a Medicare prescription drug plan, you may not be able to get this coverage back later. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

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 UMR 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.

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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