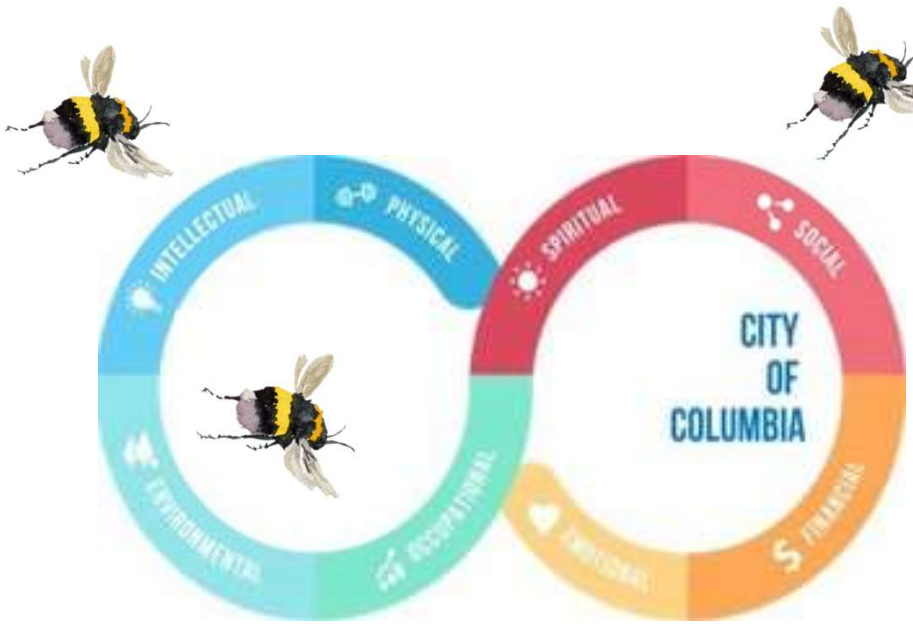
city of Columbia
Human Resources

Bee Healthy
Bee Happy

2025 BENEFITS GUIDE

City of Columbia, Missouri



2025 Benefits Overview

Welcome to the

2025 BENEFITS OPEN ENROLLMENT

It's that time of year again! The City of Columbia, MO annual insurance open enrollment period is about to begin.

We know that benefits are an integral part of the overall compensation package provided to all of our eligible employees, which is why we take great care to review all available benefits options on an annual basis. During this year's review, we focused not only on providing quality medical plans but also on controlling the cost and financial risk for our employees. We offer multiple options to meet the individual needs of our employees and their dependents.

YOU ONLY NEED TO ENROLL IF YOU WANT TO MAKE A CHANGE

- Go to www.employeenavigator.com and click Login
- Register as a new user
- Enter your first name, last name, company identifier:
- ColumbiaMo, pin and birthday
- Create your own Username and Password
- After you login, click Required Tasks

IMPORTANT DATES

Open enrollment runs

October 25 - November 15

NOT SURE HOW TO GET STARTED?

DON'T WORRY!

We will again be using our online enrollment platform through Employee Navigator (EN)! Employees will be able to make benefit elections for the 2025 Open Enrollment as well as access election information throughout the year, should you need to reference it. You can access EN from a mobile device or any laptop with internet access allowing you to seek help from friends or family to enroll. Help is also available in the IT Training Room during these times: Employee Navigator Open Enrollment Assistance.

Once you register or log in to Employee Navigator, you will want to do the following:

- Confirm your personal information is accurate,
- Add or confirm your dependent and beneficiary information (bring the social security number and date of birth for these individuals)
- Make an active election in your desired benefit plans.

Consider this booklet your open enrollment survival guide. Inside, you'll find everything you need to make informed benefits decisions, including in-depth information regarding your plan options, our policies and more.

As always, we value you as a member of the City of Columbia, MO family and look forward to a healthy and safe 2025.

REMEMBER! Open enrollment is the one time of year you can make any adjustments you'd like for the upcoming plan year.

2025 HIGHLIGHTS AT A GLANCE

- The medical and prescription drug coverage will continue with Anthem.
- The IRS required an increase to the QHDHP option deductibles to $3,300 for an individual and $6,600 for a family.
- There are no other benefit changes.
- The medical, dental and vision costs will not change.
- **This is a passive enrollment. Only employees wanting to make changes need to enroll using EN. All employees are encouraged to review their benefit statement in EN.**

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CONTACT INFORMATION

If you have any questions regarding your benefits, please call (573) 817-6445 or email HRTechs@CoMo.gov, your City of Columbia Human Resources Team or our CBIZ representative.

Want to learn more?

Throughout this guide, you'll find clickable video and link icons that will take you to resources that provide additional info on your available benefits.

MEDICAL INSURANCE
Anthem
www.anthem.com
(844) 995-1751

HEALTH SAVINGS ACCOUNT
Central Bank of Boone County
www.hsacentral.net
(833) 232-4676

DENTAL INSURANCE
Delta Dental of MO
www.deltadentalmo.com
(800) 335-8266

VISION INSURANCE
Delta Dental of MO
www.deltadentalmo.com
(877) 226-1412

LIFE/AD&D & DISABILITY INSURANCE
Anthem
www.anthem.com
(866) 551-0315

FLEXIBLE SPENDING ACCOUNTS
ASIFlex
www.asiflex.com
(800) 659-3035

ACCIDENT/CRITICAL ILLNESS/ HOSPITAL INDEMNITY
Anthem
www.anthem.com
(844) 995-1751

EMPLOYEE ASSISTANCE PROGRAM
ComPsych
www.guidanceresources.com
(800) 272-7255

YOUR CBIZ REPRESENTATIVE
Sara Miller
Samiller@cbiz.com
(314) 692-5846

Medical Insurance

YOUR HEALTH PLAN OPTIONS

As a full-time employee of City of Columbia, MO, you have the choice between two types of medical plan options: a Qualified High Deductible Health Plan (QHDHP) or a PPO Plan.

For each, your deductible will run from
January 1 - December 31.

While both plans give you the option of using out-of-network providers, you can save money by using in-network providers because Anthem has negotiated significant discounts with them. If you choose to go out-of-network, you'll be responsible for the difference between the actual charge and 140% of the rate Medicare would pay for that same service, plus your out-of-network deductible and coinsurance.

The QHDHP offers you lower premiums, the ability to establish a Health Savings Account (HSA) and the opportunity to take advantage of the HSA contributions the City makes on your behalf. These funds can be used to cover medical expenses, including deductibles, and they're yours forever — even if you leave City of Columbia, MO. Additionally, unlike a Flexible Spending Account (FSA), the HSA funds are not forfeited at the end of each year.

Get the most out of your insurance by using **in-network providers.**

HOW TO GET STARTED

SELECT YOUR MEDICAL PLAN

QHDHP with HSA

OFFERS SEVERAL BENEFITS:

- Routine preventive exams are covered at 100%
- Catastrophic coverage
- **The City of Columbia contributes $1,500 annually for single coverage and $3,000 for family coverage.** (Contributions are directly deposited into the employee's health savings account the first and second pay periods of every month at a rate of $62.50 each pay period for single coverage and $125.00 for family coverage)
- The HSA is owned by you
- You have more control over your health care dollars

PPO Plan

MAY BE FOR YOU IF ANY OF THE FOLLOWING IS TRUE:

- You are not interested in establishing a Health Savings Account
- You would rather pay more in monthly premiums and less on medical expenses when they occur
- You would rather pay a copayment for physician visits and prescription drugs, except for services coded as preventive

FREQUENTLY ASKED QUESTIONS

Q. How many hours do I need to work to be eligible for insurance benefits?
You must be a permanent employee working a minimum of 20 hours per week on a regular basis, or qualify under the ACA guidelines.

Q. Will I receive a new Medical ID card?
You will receive an ID card in the mail if you are electing medical coverage for the first time or switching between the available plan options.

Q. Does the deductible run on a calendar year or policy year basis?
A calendar year basis.

Q. How long can I cover my dependent children?
Dependent children are eligible until the end of the year in which they turn age 26.

Q. I just got hired. When will my benefits become effective?
Your medical insurance benefit will begin on the first of the month following your date of employment.

Medical Plan FAQs

Care Options & When to Use Them

YOUR CARE OPTIONS

While we recommend that you seek routine medical care from your primary care physician whenever possible, there are alternatives available to you. Services may vary, so it's a good idea to visit the care provider's website. Be sure to check that the facility is in-network by calling the toll-free number on the back of your medical ID card, or by visiting www.anthem.com.

Primary Care vs. Urgent Care vs. ER

PRIMARY CARE

- Routine, primary/preventive care
- Non-urgent treatment
- Chronic disease management

For routine, primary/ preventive care or non-urgent treatment, we recommend going to your doctor's office.

Your doctor knows you and your health history best — and already has access to your medical records. You'll also likely pay the least amount out-of-pocket.

TELEHEALTH

- Cold/flu
- Diarrhea
- Fever
- Rash
- Sinus problems

Have a video visit in minutes with a board-certified doctor 24/7 on your smartphone, tablet or computer with a webcam. No appointment is needed.

Anthem partners with LiveHealth Online to bring you care from the comfort and convenience of your home or wherever you are. Just go to livehealthonline.com.

CONVENIENCE CARE

- Common infections (ear infections, pink eye, strep throat & bronchitis)
- Flu shots & Vaccines
- Pregnancy tests
- Rashes
- Screenings

If you're unable to get to your doctor's office and your condition is not urgent/an emergency, these providers serve as a good alternative.

They are often located in malls or retail stores (such as CVS, Walgreens, Wal-Mart and Target), and generally serve patients 18 months of age or older without an appointment. Services may be provided at a lower out-of-pocket cost than an urgent care center.

URGENT CARE

- Sprains & Strains
- Small cuts
- Minor infections
- Sore throats
- Mild asthma attacks
- Back pain or strains

Sometimes you need medical care fast, but a trip to the emergency room may not be necessary. During office hours, you may be able to go to your doctor's office.

Outside regular office hours — or if you can't be seen by your doctor immediately — you may consider going to an Urgent Care Center where you can generally be treated for many minor medical problems faster than at an emergency room.

EMERGENCY ROOM

- Heavy bleeding
- Large open wounds
- Chest pain
- Spinal injuries
- Difficulty breathing
- Major burns
- Severe head injuries
- Broken Bones

An emergency medical condition is any condition (including severe pain) that you believe may result in serious injury or death without immediate medical care.

Emergency services are always considered in-network. If you receive treatment for an emergency in a non-network facility, you may be transferred to an in-network facility once your condition has been stabilized.

If you believe you are experiencing a medical emergency, go to the nearest emergency room or call 9-1-1, even if your symptoms are not described here.

Medical Insurance

Anthem	Option 1: $3,300 QHDHP Employee Cost Per Month / Pay Period	Option 2: $1,500 PPO Plan Employee Cost Per Month / Pay Period	Option 3: $750 PPO Plan Closed to New Participants Employee Cost Per Month / Pay Period
Employee Employee + Spouse Employee + Child(ren) Employee + Family 2 City EEs Married/Dom Part w/full family	$0.00 / $0.00 $393.14 / $196.57 $236.69 / $118.35 $682.51 / $341.26 $70.01 / $35.01 **(See HSA Note Below)**	$18.72 / $ 9.36 $428.88 / $214.44 $265.77 / $132.88 $733.35 / $366.68 $95.43 / $47.72	$57.47 / $ 28.74 $589.11 / $294.56 $394.75 / $197.37 $971.66 / $485.83 $214.58 / $107.29
	In-Network	**In-Network**	**In-Network**
Deductible (1) Individual / Family	$3,300 / $6,600	$1,500 / $4,500	$750 / $2,250
Coinsurance (Member Pays)	20%	20%	20%
Out-of-Pocket Maximum (2) Individual / Family	$5,000 / $10,000	$4,000 / $12,000	$3,000 / $9,000
Office Visits Preventative Care Primary Care Physician / Specialist Diagnostic Lab / X-Ray Urgent Care	Covered at 100% Deductible then 20% Deductible then 20% Deductible then 20%	Covered at 100% $25 / $50 copay Deductible then 20% $55 copay	Covered at 100% $25 / $50 copay Deductible then 20% $55 copay
Hospital Visits Inpatient Care (Facility / Physician) Outpatient Surgery Major Diagnostics & Imaging Emergency Room	Deductible then 20% Deductible then 20% Deductible then 20% Deductible then 20%	Deductible then 20% Deductible then 20% Deductible then 20% $200 copay then Ded & 20%	Deductible then 20% Deductible then 20% Deductible then 20% $200 copay then Ded & 20%
Prescription Drug Deductible Retail Tier 1 / 2 / 3 / 4 Copay Mail Order (90-day supply)	Applies, then: 20% coinsurance 20% coinsurance	Does Not Apply $10 / $35 / $75 / $150 $25 / $87.50 / $187.50 / $375	Does Not Apply $10 / $35 / $75 / $150 $25 / $87.50 / $187.50 / $375
	Out-of-Network (3)	**Out-of-Network (3)**	**Out-of-Network (3)**
Deductible Individual / Family	$5,000 / $10,000	$4,500 / $13,500	$2,250 / $6,750
Coinsurance (Member Pays)	40%	40%	40%
Out-of-Pocket Maximum Individual / Family	$10,000 / $20,000	$12,000 / $36,000	$9,000 / $27,000

(1) Family deductible is embedded in the QHDHP and PPO Plans

(2) Out-of-Pocket maximum includes all cost-sharing: deductible, coinsurance and copays

(3) All Out-of-Network services subject to deductible, coinsurance and balance billing

HSA Note—HSA participants who qualify and establish a Health Savings Account will receive an annual Employer contribution of $1,500 for single coverage and $3,000 for family coverage.

Premiums can be withheld from your paycheck on a pre-tax basis for Medical, Dental, and Vision insurance. Based upon your individual tax bracket, this could save you a considerable amount of money. Your election can only be changed during the plan year if you experience a qualifying life status change. Coverage begins the 1st of the month following the event, except for newborns who are covered at date of birth. You must notify Human Resources within 30 days of all qualifying events, including adding a newborn.

All of the plans are detailed in the Anthem Summary Plan Description (SPD). This is a brief summary only. For exact terms and conditions, please refer to the SPD.

TELEHEALTH SAVINGS

LiveHealth ONLINE

Retail Telehealth, or a "virtual visit," lets you see and talk to a doctor from your mobile device or computer without an appointment. Anthem partners with LiveHealth Online to bring you care from the comfort and convenience of your home or wherever you are.

Most visits take about 10-15 minutes, and your doctor can write a prescription, if needed, that you can pick up at your local pharmacy.

Conditions commonly treated through a virtual visit:

- Bladder infection/ urinary tract infection
- Bronchitis
- Cold/flu
- Diarrhea
- Fever
- Migraine/headaches
- Pink eye
- Rash
- Sinus problems
- Sore throat

GET STARTED TODAY WITH LIVEHEALTH ONLINE

STEP 1: Go to livehealthonline.com or download the Mobile App
The LiveHealth Online app can be downloaded directly to your smart phone or tablet. Or, if you prefer the web, visit www.livehealthonline.com.

STEP 2: Enroll
Create an account in a few simple steps. Be sure to include your Anthem insurance information when creating your account. Your information is stored securely.

STEP 3: Choose a doctor
View a list of available doctors, their experience and ratings, and select one.

STEP 4: Visit
Engage in a secure live video visit directly from the web or your mobile device in high-quality streaming video.

PHARMACY BENEFITS

THE ANTHEM FORMULARY

To find the latest drug list:

- visit anthem.com/nationaldirect4tier
- Please review the drug list for your medicine. The formulary will provide the tier to which it applies and any applicable notes.

Start saving on prescriptions:

- Ask your physician if there is a generic alternative
- Skip the line and take advantage of home delivery

GOODRX

GoodRx compares prices for your prescriptions at pharmacies near you. GoodRx does not sell medications, they tell you where you can get the best deal on them.

GoodRx will show you prices, coupons, discounts, and savings tips for your prescriptions.

You can access GoodRx by going to www.goodrx.com, or by downloading the app.

It is important to remember, if you purchase medications using GoodRx instead of your Anthem card, the cost will not be applied to your medical deductibles or out-of-pocket maximums.

GoodRx

Download on the App Store

GET IT ON Google Play

Anthem Additional Programs

SYDNEY HEALTH MOBILE APP

Discover a powerful and more personalized health app. Access your benefits and wellness tools to improve your overall health. **Sydney Health** has everything you need to know about your benefits to make the most of them while taking care of your health.

- Reminding you about important preventive care needs
- Planning and tracking your health goals, fitness and rewards
- Guiding you with insights based on your history and changing health needs
- Empowering you with personalized resources to find and compare doctors and check costs
- Quickly access your ID card
- Find a doctor in your plan using the Find Care tool

FIND A PROVIDER IN YOUR NETWORK

Go to anthem.com/findadoctor or download the Sydney App

1. Scroll down the page to Search as a Guest and click on Search by Selecting Medical (Employer-Sponsored)
2. Use the dropdown menu to select Medical as the type of care you are searching for
3. Select the state you are in from the drop down menu
4. Select your plan/network from drop down menu:
   - ⇒ In Missouri, under Medical Networks, select the Blue Access Network
   - ⇒ Outside of Missouri select National PPO (BlueCard PPO)
5. Click Continue
6. Enter additional search criteria to narrow your search

BLUECARD PPO PROGRAM

What happens if you're away from home and you need care right away? As an Anthem Blue Cross and Blue Shield (Anthem) member, you have access to care across the country through the **BlueCard® PPO Program**. This includes 92% of doctors and 96% of hospitals in the U.S.

If you're outside the U.S., you can use the **BlueCard Worldwide® Program**. It gives you access to doctors and hospitals in nearly 200 countries and territories around the world.

HEALTH & WELLNESS PROGRAMS

Whether you're suffering from asthma, expecting a baby or just fighting a cold, Anthem's health and wellness programs can help.

ConditionCare - If you have asthma, diabetes, chronic obstructive pulmonary disease (COPD), heart disease or heart failure, **ConditionCare** can give you the tools and resources you need to take charge of your health.

Future Moms - Having a baby is an exciting time! **Future Moms** can help you have a healthy pregnancy and a healthy baby. Sign up as soon as you know you're pregnant.

24/7 Nurse Line - Whether it's 3 a.m. or a lazy Sunday afternoon, you can talk to a registered nurse any time of the day or night.

SpecialOffers - As an Anthem member, you qualify for discounts on products and services that help promote better health and well-being. These discounts are available through **SpecialOffers** to help you save money while taking care of your health. To find the discounts available to you, log in to anthem.com, choose Care and select Discounts.

Health Savings Account (HSA)

UNDERSTANDING A HEALTH SAVINGS ACCOUNT (HSA)

THERE ARE TWO WAYS YOU CAN PUT MONEY INTO YOUR HSA:

1 **Regular payroll deductions** on a pre-tax basis

2 **Lump-sum contributions** of any amount, anytime, up to the maximum limit.

WHAT IS AN HSA?

An HSA is exactly what it sounds like — a savings account where you can either direct pre-tax payroll deductions or deposit money to be used to pay for current or future qualified medical expenses for you and/or your dependents.

YOUR HSA CAN ALSO BE AN INVESTMENT OPPORTUNITY.

Depending upon your HSA balance, your account can grow tax-free in an investment of your choice (like an interest-bearing savings account, a money market account, a wide variety of mutual funds — or all three). Of course, your funds are always available if you need them for qualified health care expenses.

HSA FUNDS CAN BE USED FOR YOUR FAMILY.

Your HSA doesn'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.

YOUR FUNDS CAN CARRY OVER AND EVEN GROW OVER TIME.

The money in your HSA always belongs to you, and we mean always. Even if you leave the company or you don't use a lot of health services now, your funds will carry over from year to year and will always be there if you need them in the future — even after retirement.

CONTRIBUTE UP TO $4,300 SINGLE, OR $8,550 FAMILY

(These maximums include the City's annual contribution of $1,500 for single coverage and $3,000 for family coverage.)

WHAT ARE THE RULES?

- You must be covered under a Qualified High Deductible Health plan (QHDHP) in order to establish an HSA.
- You cannot establish an HSA if you or your spouse also have a medical FSA, unless it is a Limited Purpose 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.

WHAT ELSE SHOULD I KNOW?

- You can invest up to the IRS's annual contribution limit. Contributions are based on a calendar year. The contribution limits for 2025 are $4,300 for Single and $8,550 for Family coverage. If you're age 55 or older, you are allowed to make an extra $1,000 contribution each year.
- The contributions grow tax-free and come out tax-free as long as you utilize the funds for approved services based on the IRS Publication 502, (medical, prescription drugs, dental, vision expenses and over-the-counter medications, such as allergy medicine, cold and flu, pain relievers, and feminine hygiene)
- Your unused contributions roll over from year to year and can be taken with you if you leave your current job.
- If you use the money for non-qualified expenses, then the money becomes taxable and subject to a 20% excise tax penalty (like in an IRA account).
- There is no penalty for distributions following death, disability (as defined in IRC 72), or attainment of Medicare eligibility age, but taxes would apply for non-qualified distributions.
- If your health care expenses are more than your HSA balance, you need to pay the remaining cost another way. Save your receipts in case you are ever audited! You can request reimbursement later, after you have accumulated more money in your account.

Health Savings Account (HSA)

YOU CAN USE HSA FUNDS FOR IRS-APPROVED ITEMS SUCH AS:

- Doctor's office visits
- Dental services
- Eye exams, eyeglasses, laser surgery, contact lenses and solution
- Hearing aids
- Orthodontia, dental cleanings and fillings
- Prescription drugs and some over-the-counter medications (such as allergy medicine, cold and flu, pain relievers and feminine hygiene)
- Physical therapy, speech therapy and chiropractic expenses

More information about approved items, plus additional details about the HSA, is available at irs.gov.

IMPORTANT INFORMATION:

Every time you use your HSA, save your receipt in case the IRS asks you to prove your claim was for a qualified expense. If you use HSA funds for a non-qualified expense, you will pay tax and a penalty on those funds.

The HSA is your personal account and contains your personal funds. It can be considered an asset by a creditor and garnished as applicable.

As a health savings account holder, you will be required to file a Form 8889 with the IRS each year. This form identifies any contributions, distributions, or earned interest associated with your account.

THIS MAY BE THE BEST PLAN OPTION FOR YOU IF ANY OF THE FOLLOWING ARE TRUE:

- You do not incur a lot of medical and prescription medication expenses.
- You would like money in a savings account to pay for Qualified Expenses permitted under Federal Law.
- You would like the opportunity to contribute pre-tax income to a Health Savings Account.
- You are enrolled in the QHDHP option.

What Is a Health Savings Account?

FREQUENTLY ASKED QUESTIONS

Q. What will I pay at the pharmacy with the HSA qualified plan options?

You will pay the actual discounted cost of the drug until you satisfy your calendar year deductible in full.

Q. What will I pay at the physician's office with the HSA qualified plan?

You'll provide your ID card at the time of your visit and the physician's office will submit the claim to Anthem. Generally, you will not owe anything at the time of your visit. Later, you'll receive an Explanation of Benefits (EOB) from Anthem that shows the charges discounted based on their contract with the physician. When you receive a bill from the physician's office, you pay the portion of the discounted cost you are responsible for as shown on the EOB.

Q. Where can I get a copy of an EOB?

You can access all of your EOB information, as well as obtain other important information, by logging on to anthem.com.

Flexible Spending Accounts (FSA)

- *Health Care Flexible Spending Account*
- *Limited Purpose Flexible Spending Account*
- *Dependent Care Expense Account*

(These accounts are based on a calendar year)

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

This account enables you to pay medical, dental, vision, and prescription drug expenses that may or may not be covered under your insurance program (or your spouse's) with pre-tax dollars. You can also pay for dependent health care, even if you choose single (vs. family) coverage.

LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT

This option is available for employees who choose to contribute to a Health Savings Account (HSA). The account enables you to pay for dental and vision expenses that may or may not be covered under your insurance program (or your spouse's) with pre-tax dollars without having to dip into your HSA. You can also pay for dependent dental and vision expenses, even if you choose single (vs. family) coverage.

In both accounts above, the total amount of your annual election is available to you up front, reducing the chance of having a large out-of-pocket expense early in the plan year. Be aware-any unused portion of the account at the end of the plan year is forfeited.

ELIGIBLE EXPENSES EXAMPLES

- Coinsurance & copayments
- Contraceptives
- Crutches
- Dental expenses
- Dentures
- Diagnostic expenses
- Eyeglasses, including exam fee
- Handicapped care & support
- Nutrition counseling
- Hearing devices & batteries
- Hospital bills
- Deductible amounts
- Laboratory fees
- Licensed practical nurses
- Orthodontia
- Orthopedic shoes
- Oxygen
- Prescription drugs
- Psychiatric care
- Psychologist expenses
- Routine physical
- Seeing-eye dog expenses
- Prescribed vitamin supplements (medically necessary)

HOW THE HEALTH CARE FLEXIBLE SPENDING ACCOUNT WORKS

When you have out-of-pocket expenses (such as copayments and deductibles), you can either use your FSA debit card to pay for these expenses at qualified providers or submit an FSA claim form with your receipt to ASIFlex. A reimbursement is issued to you through direct deposit into your bank account, or by check.

2025 MAXIMUM CONTRIBUTIONS

Health Care Flexible Spending account	$3,300 max
Limited Purpose Flexible Spending	$3,300 max
Dependent Care Expense account	$5,000 max

Full list of Health Care FSA Eligible Expenses

What is a Dependent Care FSA?

DEPENDENT CARE EXPENSE ACCOUNT

This account gives you the opportunity to redirect a portion of your annual pay on a pre-tax basis to pay for dependent care expenses. An eligible dependent is any member of your household for whom you can claim expenses on your Federal Income Tax Form 2441, "Credit for Child and Dependent Care Expenses."

Children must be under age 13. Qualified care centers include dependent care centers, preschool educational institutions, and qualified individuals (as long as the caregiver is not a family member and reports income for tax purposes).

Before deciding to use the Dependent Care Expense Account, it would be wise to compare its tax benefit to that of claiming a child care tax credit when filing your tax return. You may want to check with your tax advisor to determine which method is best for you and your family. Any unused portion of your account balance at the end of the plan year is forfeited.

CONTACT INFORMATION

Request a full statement of your accounts at any time by calling (800) 659-3035, or log on to asiflex.com to review your FSA balance. The address to mail claims to is: P.O. Box 6044, Columbia, MO 65205-6044.

At asiflex.com you can:

- View account information and activity
- File claims
- Manage your profile
- View notifications
- Access forms

Download the ASIFlex Mobile App!

What Is a Flexible Spending Account?

Dental Insurance

REVIEW YOUR DENTAL PLAN

DELTA DENTAL OF MISSOURI IS THE DENTAL CARRIER FOR 2025.

The dental plan is a PPO that offers coverage in- and out-of-network. It is to your advantage to utilize a network dentist in order to achieve the greatest cost savings. If you choose to go out-of-network, you will be responsible for any cost exceeding Delta Dental of MO's negotiated fees, plus any deductible and coinsurance associated with your procedure.

Dependent children are eligible until the end of the year in which they turn age 26.

What is Dental Insurance?

DENTAL INSURANCE PLAN OPTIONS AND COSTS

In-Network Providers:
Provider is reimbursed based on contracted fees and cannot balance bill you.

Out-of-Network Providers:
Provider is reimbursed based on Reasonable and Customary standards and balance billing is possible.

Delta Dental of MO	Employee Cost Per Month
Employee	$0
Employee + Spouse	$33.41
Employee + Child(ren)	$33.41
Employee + Family	$66.77
2 City EEs Married/Dom Part w/full family	$16.59

	In-Network	Out-of-Network	
Deductible Individual / Family	$25 / no max		Applies to Basic & Major Services
Annual Maximum	$1,500		Applies to Preventative, Basic & Major Services
Carrier Pays			
Diagnostic / Preventive Services	100%	100%	• Oral Evaluations & Cleanings • X-Rays • Fluoride Treatments (for dependents <19) • Sealants (for dependents <14) • Space Maintainers (for dependents <16)
Basic Services	80%	80%	• Emergency Treatment (for temporary pain relief) • Fillings • Endodontics • Periodontics • Simple & Surgical Extractions • General Anesthesia
Major Services	50%	50%	• Single Crowns • Inlays/Onlays • Bridges & Dentures
Orthodontia Services	Not Covered		Not Covered

FIND A DENTAL PROVIDER

To find a Delta Dental of MO Dental Provider in your area, visit the website at deltadentalmo.com.

- Click on "Find a Dentist"
- Select the Delta Dental PPO or Delta Dental Premier
- Enter your Zip Code then click on "Find dentists" for a comprehensive directory of dentists

REVIEW YOUR VISION PLAN

DELTA DENTAL OF MO IS THE VISION CARRIER FOR 2025.

The vision plan offers coverage both in-network and out-of-network. It is to your advantage to utilize a network provider in order to achieve the greatest cost savings. If you go out-of-network, your benefit is based on a reimbursement schedule.

In addition, if you are considering Lasik surgery or other non-covered benefits, there are discounts available with some providers. To find a participating provider, go to deltadentalmo.com/vision.

What is Vision Insurance?

VISION INSURANCE PLAN OPTIONS AND COSTS

Delta Dental of MO	Employee Cost Per Month	
Employee	$6.65	
Employee + Spouse	$13.36	
Employee + Child(ren)	$14.28	
Employee + Family	$22.84	
	In-Network	**Out-of-Network**
Examination Copay	$10 copay	**Reimbursement** Up to $40
Frequency of Service		
Exam	Every 12 months	
Lenses	Every 12 months	
Frames	Every 24 months	
Lenses		**Reimbursement**
Single	$10 copay; 100% covered	Up to $20
Bifocal	$10 copay; 100% covered	Up to $40
Trifocal	$10 copay; 100% covered	Up to $60
Lenticular	$10 copay; 100% covered	Up to $100
Frames	$0 copay; $130 allowance, 20% off balance over $130	**Reimbursement** Up to $52
Conventional Contacts	$10 copay; $130 allowance, 15% off balance over $130	**Reimbursement** Up to $78
Medically Necessary Contacts	$10 copay, $250 allowance	**Reimbursement** Up to $250

FIND A VISION PROVIDER

To find a Delta Dental of MO Dental Provider in your area, visit the website at deltadentalmo.com.

- Click on “Find a Vision Provider”
- Enter your Zip Code then click on “Search by Zip” for a comprehensive directory of dentists

Life Insurance and AD&D

REVIEW YOUR LIFE INSURANCE POLICY

- *Add Your Spouse*
- *Add Your Dependents*
- *Increase Your Coverage*

BASIC LIFE AND AD&D

City of Columbia, MO provides 1½ x your annual earnings to a maximum of $50,000 in Basic Term Life and Accidental Death & Dismemberment (AD&D) insurance.

This coverage is offered through Anthem at no cost to you **IF** you are a full-time employee. Permanent Part-Time employees will share in the cost based on each FTE %.

What is Life and AD&D Insurance?

VOLUNTARY TERM LIFE AND DEPENDENT LIFE

You can purchase additional Term Life Coverage beyond what City of Columbia, MO provides. Anthem guarantees issued coverage during your initial enrollment period — which means you can't be turned down for coverage based on medical history.

- **Voluntary Employee Life:** minimum $10,000 to a maximum of 3x your annual salary or $200,000, by electing 1, 2 or 3 times your annual salary. *Guarantee issue up to $100,000.*
- **Optional Spouse Life:** minimum $5,000 up to 50% of the employee amount, to $100,000 by electing .5, 1 or 1.5 times the employee's salary. *Guarantee issue up to $25,000.*
- **Optional Child Life:** $10,000. *Guarantee issue is $10,000.* (Children 15 days to 6 month have a $250 benefit.)

If you don't enroll in the Voluntary Life plan during your initial enrollment period with Anthem, you'll be required to complete an Evidence of Insurability form and be approved by Anthem before you're able to get coverage in the future.

You must be enrolled in voluntary life coverage in order for your spouse, and/or eligible dependent children to enroll.

Additional Benefits for Base Life/AD&D participants:

- **Travel assistance** helps with unexpected emergencies while traveling more than 100 miles from home.
- **Resource Advisor** offers services at no extra cost for six months after a loss.

DID YOU KNOW? City of Columbia, MO provides you Basic Life and AD&D ***AT NO CHARGE.***

BASIC DEPENDENT LIFE

Three Basic Dependent Life options are available to all employees. Coverage applies to all eligible dependents, including spouse and/or child, whichever is applicable. Upon enrollment (or following approval if applying for coverage late), a flat rate is charged per employee and is deducted out of the last paycheck of each month. A comparison of the three plans is shown here.

BASIC DEPENDENT LIFE OPTIONS			
COVERED DEPENDENT	**Dependent Plan 1** *Cost = $.69 ee/mo.*	**Dependent Plan 2** *Cost = $.98 ee/mo.*	**Dependent Plan 3** *Cost = $1.38 ee/mo.*
Spouse*	$5,000	$7,500	$10,000
Child (15 days – 26 yrs.)	$2,000	$2,500	$4,000

***Please note, benefits begin to reduce by 50% at age 70.**

VOLUNTARY LIFE/DEPENDENT LIFE OPTIONS AND COSTS PER MONTH

Anthem	Rates per $1,000 of coverage		
	Age	***Employee***	***Spouse****
Voluntary Life	<24	$0.080	$0.080
	25-29	$0.090	$0.090
	30-34	$0.100	$0.100
	35-39	$0.130	$0.130
	40-44	$0.180	$0.180
	45-49	$0.260	$0.260
	50-54	$0.400	$0.400
	55-59	$0.630	$0.630
	60-64	$1.000	$1.000
	65-69	$1.90	$1.90
	70+	$3.09	$3.09
	Child(ren)	$2.10 for $10,000	

**Spouse rate is based on the spouse's age.*

Note: Benefits begin to reduce at age 70 applicable to both the employee and spouse.

REVIEW YOUR DISABILITY INSURANCE

LONG-TERM DISABILITY INSURANCE

Long-Term Disability (LTD) insurance is offered through Anthem. The City of Columbia, MO pays 100% of the premiums. A pre-existing conditions clause applies and immediate benefits will not be paid if you have received treatment for a condition within 6 months prior to your effective date until you have been covered for 12 months.

The plan benefit is up to 66.67% of basic monthly earnings up to a maximum of $5,000 per month. The benefits begin after a 180 day waiting period. Benefits can continue up to the Social Security Normal Retirement Age.

Additional Benefits for Base Life/AD&D participants:

- **Resource Advisor** offers services at no extra cost if you are unable to work.

What is Long Term Disability?

WHY IS EMPLOYER PROVIDED DISABILITY INSURANCE VALUABLE?

Many workers think these events are more likely than becoming disabled during their careers. Here are the actual odds:

- **.0000004%** - *Winning Mega Millions*
- **.02%** - *Being Struck by Lightning*
- **1%** - Being audited by the *IRS*
- **3%** - *Having twins*
- **25%** - *Becoming disabled*

Nearly **40 million**
American adults live with a disability.

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.**

Voluntary Coverages

PROTECT YOUR FINANCES

- *Hospital Indemnity*
- *Accident Insurance*
- *Critical Illness*

SUPPLEMENTAL HOSPITAL INDEMNITY

This coverage offers protection for hospitalization when a sickness or injury occurs. This is especially helpful when an insured is hospitalized before their major medical deductible has been met, providing a financial safety net.

ANTHEM HOSPITAL INDEMNITY INSURANCE COVERS THE FOLLOWING:

- Initial and daily hospital confinement
- Initial and daily ICU confinement

FEATURES:

- Coverage is guaranteed-issue (which means you will qualify for coverage without having to answer health questions)
- Benefits are paid directly to you (unless you choose otherwise)
- Coverage is available for you, your spouse, and your dependent children
- Coverage is portable (with certain stipulations). That means you can take it with you if you change jobs or retire
- Fast claims payment. Most claims are processed in about four business days

BENEFITS INCLUDE:

- No pre-existing conditions limitation
- No pregnancy waiting period
- Applies to all Illness and Injury which occur after the effective date of the policy

Hospital Indemnity Insurance			
Employee	Employee & Spouse	Employee & Children	Family
$22.73	$47.33	$34.97	$61.24

What is Hospital Indemnity?

HOW ACCIDENT INSURANCE WORKS

1. You select "Accident Insurance"

2. You injure your leg in a covered accident and go to the hospital by ambulance

3. The ER doctor diagnoses a fracture and treats you

4. You leave the hospital on crutches

5. Anthem pays your benefit

OFF-THE-JOB ACCIDENT INSURANCE

If you're like most people, you don't budget for life's unexpected moments. One mishap can send you on an unexpected trip to your local emergency room — and leave you with a flurry of unexpected bills.

That's where Accident Insurance jumps in. In the event of a covered accident, the plan pays you cash benefits fast to help you pay for the costs associated with out-of-pocket expenses and bills — expenses major medical may not take care of.

ANTHEM ACCIDENT INSURANCE COVERS THINGS LIKE THE FOLLOWING:

- Ambulance rides
- Wheelchairs, crutches, and other medical appliances
- Emergency room visits
- Surgery and anesthesia
- Bandages, stitches, and casts

FEATURES:

- Coverage is guaranteed-issue (which means you will qualify for coverage without having to answer health questions)
- Benefits are paid directly to you (unless you choose otherwise)
- Coverage is available for you, your spouse, and your dependent children
- Coverage is portable (with certain stipulations). That means you can take it with you if you change jobs or retire
- Fast claims payment. Most claims are processed in about four business days

BENEFITS INCLUDE:

- Transportation and Lodging Benefits
- An Emergency Room Treatment Benefit
- A Rehabilitation Unit Benefit
- Coverage for certain serious conditions, such as coma and paralysis
- An Accidental-Death Benefit
- A Dismemberment Benefit

What is Accident Insurance?

Accident Insurance			
Employee	Employee & Spouse	Employee & Children	Family
$8.87	$18.22	$19.30	$30.40

Voluntary Coverages (cont.)

CRITICAL ILLNESS INSURANCE

While it is impossible to prepare for the physical and emotional consequences of being diagnosed with a critical illness, you can prepare for the consequences such an illness may have on your personal finances.

While major medical insurance may pay for a good portion of the costs associated with the illness, there are a lot of expenses that are just not covered — from deductibles and copays to living expenses.

This Critical Illness insurance policy from Anthem can help with the treatment costs of a covered critical illnesses — such as a heart attack or stroke. More importantly, it can help you focus on recuperation instead of the distraction of out-of-pocket costs.

With the Critical Illness plan, you receive cash benefits directly (unless otherwise assigned) — giving you the flexibility to help pay bills related to treatment or to help with everyday living expenses.

FEATURES:

- Benefits are paid directly to you, unless you choose otherwise
- Coverage is available for you, your spouse, and dependent children
- You can take your coverage with you if you change jobs or retire (with certain stipulations)
- Fast claims payment (most claims are processed in about four days)

GROUP CRITICAL ILLNESS COVERAGE INCLUDES:

- Health Screening Benefit—**$100**
- Critical Illness Benefit payable for:

* Cancer	* Major organ transplant	* Non-invasive cancer
* Heart attack (myocardial infarction)	* Bone marrow transplant (stem cell transplant)	* Skin cancer
* Stroke	* Sudden cardiac arrest	
* Kidney failure (end-stage renal failure)	* Coronary artery bypass surgery	

What is Critical Illness Insurance?

HOW CRITICAL ILLNESS COVERAGE WORKS

1. Critical illness coverage is selected at the $20,000 benefit amount

2. You experience chest pains and numbness in your left arm

3. You visit the emergency room

4. A physician determines that you have suffered a heart attack

5. Anthem Critical Illness coverage pays you a First Occurrence Benefit of $20,000

CRITICAL ILLNESS INSURANCE COSTS:

Rates are displayed as monthly payroll deductions.

Critical Illness - $10,000 Basic Benefit Amount ($5,000 for spouse/$5,000 for children)								
	Non-Tobacco User				Tobacco User			
Issue Age	Employee	Employee & Spouse	Employee & Children	Family	Employee	Employee & Spouse	Employee & Children	Family
18-24	$5.12	$9.28	$8.81	$13.59	$5.23	$9.46	$8.93	$13.77
25-29	$5.95	$10.63	$9.64	$14.94	$6.21	$11.03	$9.90	$15.35
30-34	$6.40	$11.40	$10.10	$15.71	$6.91	$12.20	$10.60	$16.50
35-39	$7.26	$12.72	$10.96	$17.02	$8.27	$14.28	$11.97	$18.59
40-44	$8.84	$15.26	$12.54	$19.56	$10.77	$18.28	$14.46	$22.59
45-49	$11.41	$19.39	$15.10	$23.69	$15.39	$25.61	$19.08	$29.91
50-54	$14.22	$23.78	$17.92	$28.09	$21.23	$34.64	$24.92	$38.95
55-59	$18.22	$30.05	$21.92	$34.35	$29.67	$47.76	$33.37	$52.07
60-64	$24.37	$39.63	$28.07	$43.94	$42.96	$68.28	$46.65	$72.59
65-69	$32.06	$51.42	$35.76	$55.73	$60.97	$95.90	$64.66	$100.22
70-74	$43.02	$68.24	$46.72	$72.55	$81.54	$127.82	$85.23	$132.13
75-79	$57.34	$89.95	$61.03	$94.25	$98.96	$154.51	$102.65	$158.81
80-84	$66.47	$103.80	$70.16	$108.10	$110.10	$171.70	$113.80	$176.01

Critical Illness - $20,000 Basic Benefit Amount ($10,000 for spouse/$10,000 for children)								
	Non-Tobacco User				Tobacco User			
Issue Age	Employee	Employee & Spouse	Employee & Children	Family	Employee	Employee & Spouse	Employee & Children	Family
18-24	$6.68	$11.57	$10.87	$16.46	$6.91	$11.93	$11.11	$16.81
25-29	$8.06	$13.75	$12.25	$18.64	$8.59	$14.56	$12.78	$19.45
30-34	$8.84	$15.02	$13.03	$19.91	$9.86	$16.60	$14.04	$21.48
35-39	$10.49	$17.51	$14.69	$22.38	$12.50	$20.65	$16.70	$25.52
40-44	$13.37	$21.98	$17.55	$26.86	$17.23	$28.04	$21.41	$32.91
45-49	$18.24	$29.61	$22.44	$34.50	$26.19	$42.05	$30.38	$46.94
50-54	$23.78	$38.21	$27.96	$43.10	$37.79	$59.95	$41.99	$64.83
55-59	$31.65	$50.52	$35.84	$55.40	$54.57	$85.95	$58.76	$90.84
60-64	$43.86	$69.45	$48.05	$74.34	$81.02	$126.75	$85.21	$131.63
65-69	$59.08	$92.71	$63.27	$97.60	$116.88	$181.68	$121.08	$186.57
70-74	$80.90	$126.14	$85.10	$131.02	$157.93	$245.30	$162.13	$250.18
75-79	$109.44	$169.35	$113.63	$174.24	$192.67	$298.48	$196.87	$303.36
80-84	$127.67	$196.99	$131.87	$201.87	$214.94	$332.80	$219.13	$337.69

Voluntary Coverages (CI Rates cont.)

CRITICAL ILLNESS INSURANCE COSTS:

Rates are displayed as monthly payroll deductions.

Critical Illness - $30,000 Basic Benefit Amount ($15,000 for spouse/$15,000 for children)								
	Non-Tobacco User				Tobacco User			
Issue Age	Employee	Employee & Spouse	Employee & Children	Family	Employee	Employee & Spouse	Employee & Children	Family
18-24	$8.24	$13.87	$12.93	$19.33	$8.60	$14.40	$13.28	$19.86
25-29	$10.18	$16.88	$14.87	$22.34	$10.96	$18.09	$15.65	$23.55
30-34	$11.29	$18.64	$15.97	$24.10	$12.80	$21.00	$17.49	$26.46
35-39	$13.73	$22.29	$18.41	$27.76	$16.74	$27.00	$21.42	$32.46
40-44	$17.89	$28.70	$22.57	$34.16	$23.68	$37.78	$28.37	$43.25
45-49	$25.07	$39.84	$29.76	$45.31	$37.00	$58.49	$41.69	$63.95
50-54	$33.33	$52.65	$38.02	$58.11	$54.35	$85.25	$59.04	$90.70
55-59	$45.08	$70.98	$49.77	$76.45	$79.46	$124.14	$84.14	$129.60
60-64	$63.34	$99.28	$68.02	$104.73	$119.08	$185.22	$123.77	$190.68
65-69	$86.10	$134.00	$90.78	$139.46	$172.80	$267.45	$177.49	$272.92
70-74	$118.78	$184.03	$123.47	$189.50	$234.33	$362.78	$239.01	$368.24
75-79	$161.55	$248.76	$166.23	$254.22	$286.40	$442.45	$291.09	$447.91
80-84	$188.88	$290.18	$193.57	$295.64	$319.78	$493.90	$324.46	$499.37

Paid Time Off Policy

PAID TIME OFF

Full-time permanent employees working 40 hours per week accrue time off according to the schedule to the right:

56-Hour Fire Dept. Employees

Type of Leave	Amount Available Per Year and When You Become Eligible
Vacation	6 twenty-four hour days per employment year (5.54 hrs. per pay period) for the first 5 years; increased by 28 hours every 5 years through the 20th year; may be used after 6 months of employment
Sick*	18 days per year (accrued at 9.23 hours per pay period)
Floating Holidays	4 days per fiscal year; prorated in first year; may be used after 12 months of employment
Holidays	6 holidays (24 hours per day) and 4 holidays (11.25 hours per day) per fiscal year; beginning at hire

40-Hour Permanent Employees

Type of Leave	Amount Available Per Year and When You Become Eligible
Vacation	11 eight-hour days per employment year (3.38 hrs. per pay period) for first five years; increased by 2.5 days every 5 years through the 20th year; may be used after 6 months of employment
Sick*	18 days per year (accrued at 5.54 hours per pay period)
Floating Holidays	4 days per fiscal year; prorated in first year; may be used after 12 months of employment
Holidays	10 holidays (8 hours per day) per fiscal year; beginning at hire

***Sick Leave Buy Back:** You may sell accrued unused sick leave days earned in the previous FY once you accumulate a sick leave balance in excess of the number of hours you normally work in a 26-week period (for example 1,040 for a 40 hour per week employee).

Paid Family and Medical Leave

PAID FAMILY AND MEDICAL LEAVE (PFML)

The City of Columbia is committed to a culture that helps our employees meet the demands of family and employment responsibilities. Therefore, it is our policy to provide up to six (6) weeks of paid family and medical leave (PFML) in a 12-month period to eligible employees as defined below.

Eligibility To be eligible for Paid Family and Medical leave (PFML), an employee must be a permanent employee eligible and approved for FMLA by the City's third-party administrator.

Use of PFML, Rate of Pay and Leave Accruals While on Leave PFML will be subject to the following general requirements:

1. Eligible employees are entitled to take up to six (6) weeks of PFML in a single 12-month period for an approved qualifying event. The amount of PFML available to an employee is calculated using a rolling 12-month period (backwards).

2. Any PFML taken for the birth/adoption/foster care placement of a child must be completed within one year after the date of birth or placement.

3. Employees will be compensated at the employee's regular, base hourly rate of pay.

4. PFML shall run concurrently with federal FMLA.

5. All eligible accruals including PFML must be used prior to going into non-pay status.

How to Request PFML If an employee requests leave for a reason that the employee believes qualifies under this policy, the employee must comply with all FMLA procedures and their department time and attendance policy. Failure to comply with the department's absence reporting policies and procedures or to provide documentation or information requested may result in delay or denial of requested time off and/or discipline.

Reinstatement If an employee timely returns from PFML and used the leave for the stated purpose, the employee will be reinstated to the same position held when leave began, or to an equivalent position with equivalent benefits, pay and other terms and conditions of employment.

Before returning to work from continuous PFML for the employee's own serious health condition, the employee is required to submit a City of Columbia Return to Duty Authorization Form completed by their treating health care provider releasing the employee to perform the essential functions of their job. Employees in certain public safety and DOT positions, as defined by department specific rules, are also required to be evaluated by the City's employee medical advisor prior to returning to work.

Prohibitions The following conduct is strictly prohibited in relation to PFML:

- Engaging in fraud, misrepresentation or providing false information to obtain leave.
- Failure to comply with the employee's obligations in accordance with city policy.
- Failure to timely return from the leave.

Employees who engage in such conduct will be subject to loss of benefits, denial or termination of PFML, and discipline up to and including termination.

EMPLOYEE ASSISTANCE PROGRAM

Each day we juggle all parts of our lives . . . work, family fun . . . usually balancing them with success. On occasion, however, a personal situation may become so overwhelming it can interfere with our job, everyday life and sometimes our future. There may be times you need outside help and guidance. The ComPsych Employee Assistance Program currently offers help to employees and their families.

What is the Employee Assistance Program? The Employee Assistance Program (EAP) is a confidential assessment, short-term counseling and referral service that provides direction to troubled employees and their families.

Why have an Employee Assistance Program? Because we care about you as a valued employee. We also recognize that personal issues arise that can affect job performance. Seeking help with issues is a healthy way to keep your life and career on a steady course. That's why we're giving you an EAP.

What services does the program help with? EAP deals with all kinds of issues . . . marriage, family, emotional, abuse, alcohol, drugs, adjusting to life changes, retirement, death in the family, etc. Sometimes short-term counseling is all you need to manage these life changes and get you back on the right track. The EAP can also assist with legal, financial, identity theft, and work life referral services. There are also a variety of on-line resources available as well.

What is the cost? Permanent City employees may take advantage of this benefit and it is paid for by the City of Columbia. There is no cost to you for the 8 EAP sessions per issue per year. EAP is a benefit for you and all of your household members (roommates, relatives, partners or children). If the issue requires a referral to an outside agency or professional, you then would be responsible for the cost. The EAP counselor will assist you in determining the kind of help you need.

What about confidentiality? Confidentiality is the foundation of this program. In fact, the program could not exist without it. Disclosure of information occurs only with a signed release from the employee or when law mandates release.

What now? If you have more questions or feel a need to contact EAP, call toll free 800-272-7255 or go online at guidanceresources.com (WEB ID: COM589) and then create your own username and password. If you have any difficulties accessing the web content, please contact Human Resources or call the ComPsych number listed above. You don't have to let an issue escalate to the point of jeopardizing your job or personal well-being.

We believe strongly in our commitment to you. That's why we are providing you with an Employee Assistance Program.

EAP COVERGE INCLUDES:

- Stress Management
- Depression/Anxiety/Panic Attacks
- Elder Care Resources/Child Care Needs
- Relationship/Family Concerns
- Chemical Dependency
- Eating Disorders
- Domestic Violence
- Grief or Loss
- Financial Guidance
- Legal Guidance
- Online Resources

What is an EAP?

RETIREMENT BENEFITS

Prepare for the future with retirement benefits. It is never too early to start planning for retirement. The City helps you prepare for a secure financial future.

Missouri Local Government Employees Retirement System (LAGERS) This plan is fully funded by the City and provides a retirement benefit to all employees, except full-time regular firefighters, full-time regular police offers and railroad operations employees, working one thousand five hundred (1,500) hours or more in a calendar year for the remainder of your life based on your years of service and final average salary for your highest 36 consecutive months in the ten years prior to retirement.

The City has elected Rule of 80, which means that when your age plus service credit (or time you've worked in LAGERS covered employment) equals 80, you can retire with no reduction in your benefit. This is *not* the same as the LAGERS' early retirement option, which does reduce your benefit depending on how early you decide to retire, before normal retirement age. For more information about LAGERS benefits and the Rule of 80, visit www.molagers.org.

You become vested, or entitled to, your benefit when you complete five years of full-time employment or immediately if your death is work-related. You may receive an early retirement benefit at age 55, but the benefits are reduced to account for the longer period you will receive benefits.

The plan also provides a death benefit payable to your eligible spouse or children if you die with a vested benefit before you retire.

If you are unable to work due to injury or illness and qualify under the terms of the plan, you can apply for a disability benefit as well.

Columbia Police & Firefighter Pension Eligible employees contribute to this plan, which provides a retirement benefit for the remainder of your life based on your years of service and final average salary for your highest 36 months of covered employment. You become vested, or entitled to, your benefit when you complete one year of service. Firefighters employed after 10/1/2012 are eligible for retirement benefits upon reaching age 55 or when age and active service equals 80. Police Officers employed after 10/1/2012 are eligible for retirement benefits upon reaching age 65 or 25 years of credited service.

The plan also provides a death benefit if you die with a vested benefit before you retire or while you are disabled.

If you are unable to work due to injury or illness and qualify under the terms of the plan, you can apply for a disability benefit as well.

457 Deferred Compensation Plan You are eligible to participate in the 457 Deferred Compensation Plan if you are a full-time or part-time employee. Contributions are deducted from your pay before taxes are taken. The IRS limits the dollar amount you can contribute to any qualified plan in a calendar year. The limit for 2025 is $23,000. If you are age 50 or over, you may also contribute an additional $8,000 in 2025 under the "catch-up contribution" rule. You are always 100% vested in your account and you can move the money to another qualified 457 plan, withdraw the funds, or leave the money in this plan if you terminate employment. You must begin receiving payments from your 457 plan by the time you reach age 73.

401(a) Plan Permanent employees may, at their option, participate in the City's Money Purchase Plan, a defined contribution plan operating under Section 401(a) of the Internal Revenue Code of 1986. Subject to the provisions of the plan and the limitations imposed by Section 401(a)(4) of the Internal Revenue Code of 1986, the city will contribute to the plan trust fund on behalf of each participating employee who contributes to a group deferred compensation plan (457 plan) at the minimum rate of two dollars ($2.00) per pay period, an amount equal to the employee's contribution to the 457 plan up to a maximum of two (2) percent of the employee's compensation. Police and firefighter employees participating in the city's Police and Fire Pension Plans are not eligible to participate in the Money Purchase Plan.

As with the 457 Plan, you can move the money to another qualified plan, withdraw the funds, or leave the money in this plan if you terminate employment.

Glossary of Medical Terms

INSURANCE TERMS

Coinsurance—The plan's share of the cost of covered services which is calculated as a percentage of the allowed amount. This percentage is applied after the deductible has been met. You pay any remaining percentage of the cost until the out-of-pocket maximum is met. Coinsurance percentages will be different between in-network and out-of-network services.

Copays—A fixed amount you pay for a covered health care service. Copays can apply to doctor's office visits, as well as urgent care and emergency room services. Copays will not satisfy any part of the deductible. Copays should not apply to any preventive services.

Deductible—The amount of money you pay before services are covered. Services subject to the deductible will not be covered until it has been fully met. It does not apply to any preventive services, as required under the Affordable Care Act.

> ***Embedded Deductible–** The single team member deductible is *embedded* into the family deductible, meaning no one person covered under the plan can contribute more than the single amount toward the family deductible.

Lifetime Benefit Maximum—All plans are required to have an unlimited lifetime maximum.

Network Provider—A provider who has a contract with your health insurer or plan to provide services at set fees. These contracted fees are usually lower than the provider's normal fees for services.

Out-of-Pocket Maximum—The most you will pay during a set period of time before your health insurance begins to pay 100% of the allowed amount. The deductible, coinsurance and copays are included in the out-of-pocket maximum.

Preauthorization (also known as Prior Authorization (PA))—A process conducted by your health insurer or plan to determine if any service, treatment plan, prescription drug or durable medical equipment is medically necessary. This is sometimes called prior authorization, prior approval or precertification.

UCR (Usual, Customary and Reasonable)—The amount paid for medical services in a geographic area based on what providers in the area usually charge for the same or similar service.

MEDICAL TERMS

Prescription Drugs—Each plan offers its own unique prescription drug program. Specific copays apply to each tier and a medical plan can have one to five separate tiers. The retail pharmacy benefit offers a 30-day supply. Mail order prescriptions provide up to a 90-day supply. Sometimes the deductible must be satisfied before copays are applied.

Urgent Care—Care for an illness, injury or condition serious enough that a reasonable person would seek immediate care, but not so severe to require emergency room care.

Emergency Room—Services you receive from a hospital for any serious condition requiring immediate care.

Preventive Services—All services coded as Preventive must be covered 100% without a deductible, coinsurance or copayments.

Medically Necessary—Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, which meet accepted standards of medicine.

Video Resources

MEDICAL PLANS

- Medical Plans Explained
- Primary Care vs. Urgent Care vs. ER
- PPO Overview
- HDHP vs. PPO
- HDHP with HSA Overview

IMPORTANT DATES

Open enrollment runs

OCTOBER 25 - NOVEMBER 15

INSURANCE 101

- Benefits Key Terms Explained
- How to Read an EOB
- What is a Qualifying Event?

TAX ADVANTAGE SAVINGS ACCOUNTS

- What is a Health Savings Account?
- What is a Flexible Spending Account?
- What is a Dependent Care FSA?

ANCILLARY BENEFITS

- What is Dental Insurance?
- What is Vision Insurance?
- What is Life and AD&D Insurance?
- What is Accident Insurance?
- What is Critical Illness Insurance?
- What is Long Term Disability?
- What is Hospital Indemnity?
- What is an EAP?

MEDICARE PART D CREDITABLE COVERAGE

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

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

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

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

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current City of Columbia, MO coverage **may** be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop the City of Columbia, MO medical plan, **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 City of Columbia, MO and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

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

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	October 1, 2025
Name of Entity/Sender:	City of Columbia, MO
Contact-- Position/Office:	Heather Russell
Address:	701 E. Broadway, Columbia, MO 65205
Phone Number:	573-874-7677

This notice is a summary. For a full description of all of City of Columbia Benefit plans, please refer to the Summary Plan Descriptions.

Important 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 list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322, Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecover_y.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization - act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website:https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

Important Notices

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-_services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/_dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-_medicaid-health-insurance-premium-payment-program-_hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program| Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-_assistance/famis-selecthttps://coverva.dmas.virginia.gov/learn/premium-_assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/_http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and- eligibility/ Phone: 1-800-251-1269

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

U.S. Department of Labor

U.S. Department of Health and Human Services

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)

Important Notices

MARKETPLACE COVERAGE OPTIONS *FOR NEW HIRES ONLY*

PART A: GENERAL INFORMATION

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

DOES EMPLOYMENT-BASED HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 8.39% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 8.39% of the employee's household income.[12]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

MARKETPLACE COVERAGE OPTIONS CONTINUED *FOR NEW HIRES ONLY*

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.

Employer Name: City of Columbia, MO	**Employer Identification Number (EIN):** 43-10000336
Employer Address: 701 E. Broadway, Columbia, MO 65205	**Employer Phone Number:** 573-874-7677
Who can we contact about employee health coverage at this job? Heather Russell	**Phone Number:** 573-874-7677 **Email Address:** Heather.Russell@CoMo.gov

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

- As your employer, we offer a health plan to:

  ☒ All employees. Eligible employees are: full time employees, working a minimum 20 hours per week on a regular basis. Employees will be effective the first day of the month following date of hire.

- With respect to dependents:

  ☒ We do offer coverage. Eligible dependents are: defined in the Anthem Summary Plan Description.

☒ 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.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Above is 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.

Important Notices

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the deductibles and coinsurance shown in the medical benefits page apply. If you would like more information on WHCRA benefits, call your Plan Administrator at 573-874-7677.

IMPORTANT INFORMATION REGARDING 1095 FORMS

As an employer with 50 or more full-time employees, we are required to provide 1095-C forms to each employee who was employed as a full-time employee for at least one month during the calendar year, without regard to whether they were covered by our group health plan. These employees should expect to receive their Form 1095-C in early March 2025. We are also required to send a copy of your 1095-C form to the IRS. The information reported on Form 1095-C is used in determining whether an employer owes a payment under the employer shared responsibility provisions under section 4980H. Form 1095-C is also used by you and the IRS to determine eligibility for the premium tax credit.

SPECIAL ENROLLMENT NOTICE

During the open enrollment period, eligible employees are given the opportunity to enroll themselves and dependents into our group health plans.

If you elect to decline coverage because you are covered under an individual health plan or a group health plan through your parent's or spouse's employer, you may be able to enroll yourself and your dependents in this plan if you and/or your dependents lose eligibility for that other coverage. You must request enrollment within 30 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll any new dependent within 30 days of the event.

If you or your dependents become ineligible for Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

If you or your dependents become eligible for premium assistance from Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

To request special enrollment or obtain more information, contact Human Resources.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personally identifiable health information. Although City of Columbia, MO may use aggregate information it collects to design a program based on identified health risks in the workplace, the health plan will never disclose any of your personal health 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 individuals who will receive your personally identifiable health information are health professionals in order to provide you with services under the wellness program.

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 Heather Russell at 573-874-7677.

Your Notes