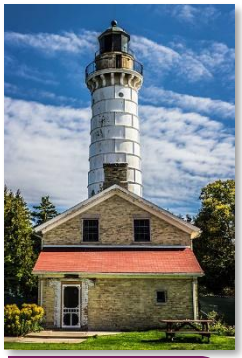

DOOR COUNTY

2026 Benefit Guide

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

Please see page 44 for more details.

Table of Contents

This brochure summarizes the benefit plans that are available to County of Door eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits

Benefits Information When You Need It Most

SCAN ME

County of Door

FIND IT IN THE APP STORE

Search for '**MyBenefits2GO**' and download our free app.

Enter this code when prompted: **L38846**

HIGHLIGHTS OF THE MyBenefits2GO APP

- Access benefits information on the go
- Convenient contact information for Carriers and HR
- Organized plan information in one place
- View the most updated plan information
- Store your ID cards in the app

MyBenefits2GO: FREE MOBILE BENEFITS APP FOR ANDROID AND IPHONE

The MyBenefits2GO app gives you on-the-go access to your benefit and insurance policy details, HR contact information and more!

The app is a quick and simple way for you and your enrolled dependents to access benefit summaries and other important information about our group plans. Store photos of ID cards in the app and easily locate carrier and HR contact information—all in one place. The MyBenefits2GO app is free for iPhone and Android.

Getting In Touch

The app provides employees and their enrolled dependents single-point contact information for benefits resources and insurance carriers.

Lightening Wallets

The app allows you to store and share images of your ID cards, freeing up space and giving you access when you need it.

Keeping Up-to-Date

The app automatically connects you with the most updated plan information and allows for message reminders from your employer.

Staying Organized

The app gives you access to benefit plan information and ID cards—all in one place.

USI

Welcome

At County of Door, we recognize our ultimate success depends on our talented and dedicated workforce. We understand the contribution each employee makes to our accomplishments and so our goal is to provide a comprehensive program of competitive benefits to attract and retain the best employees available. Through our benefits programs we strive to support the needs of our employees and their dependents by providing a comprehensive benefit package that is easy to understand and easy to access for all our employees. This guide gives you a brief description of the benefits offered and is not intended to be a complete source of information on the plans. Please refer to the plan documents for complete information.

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Benefits for You & Your Family

County of Door is pleased to announce our 2026 benefits program, which is designed to help you stay healthy, feel secure, and maintain a work/life balance. Offering a competitive benefits package is just one way we strive to provide our employees with a rewarding workplace. Please read the information provided in this guide carefully. For full details about our plans, please refer to the summary plan descriptions. Listed below are the County of Door benefits available during open enrollment:

- Medical
- Dental
- Vision
- FSA Plan
- Wellness

Who is Eligible?

Full-time and part-time employees working at least 24 hours per week, and their eligible dependents may participate in the County of Door benefits program.

Generally, for the County of Door benefits program, dependents are defined as:

- Your spouse
- Dependent “child” up to age 26. (Child means the employee’s natural child or adopted child and any other child as defined in the certificate of coverage) If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided. Children may include natural, adopted, stepchildren and children obtained through court- appointed legal guardianship.

When and How Do I Enroll?

New hires will have 30 days from their start date to enroll in benefits.

When is My Coverage Effective?

The effective date for your benefits is the first of the month following your hire date. Employees that start on the first of the month, will have benefits effective for that month.

Changing Coverage During the Year

You may make benefit changes within 30 days of a qualified event. Qualified events include marriage, divorce, legal separation, change in child’s dependent status, death of dependent, change in residence due to an employment transfer for you or your spouse or change in spouse’s benefits or employment status. You may make benefit changes within 60 days of the birth, or adoption of a child.

Note: Employee is responsible for notifying Human Resources of any changes within the time limits listed above.

Medical Benefits Overview

County of Door offers medical coverage with Auxiant as the claim's administrator and Health Payment Systems (HPS) as the medical network. Pharmacy coverage is administered by SmithRx. Below is a brief outline of the plan. Please refer to the summary plan description for complete plan details.

Medical and Pharmacy		
Benefits Coverage	In-Network Benefits	Out-of-Network Benefits
Annual Deductible		
Individual	$2,500	$3,500
Family	$5,000	$7,000
Coinsurance	90%	70%
Maximum Out-of-Pocket (Deductible and Coinsurance)		
Individual	$3,500	$5,000
Family	$7,000	$10,000
Maximum Out-of-Pocket (Includes Medical and Prescription Drug Copays)		
Individual	$5,600	Unlimited
Family	$11,200	Unlimited
Physician Office Visit		
Primary Care	$35 Copay	$35 Copay, Deductible, then coinsurance
Specialty Care	$50 Copay	$50 Copay, Deductible, then coinsurance
Preventive Care		
Adult Preventive Exams	100% Deductible waived	70% Deductible waived
Well-Child Care	100% Deductible wavied	70% Deductible waived
Diagnostic Services		
X-ray and Lab Tests	Deductible, coinsurance	Deductible, coinsurance
Complex Radiology	Deductible, coinsurance	Deductible, coinsurance
Urgent Care Facility	$50 Copay	$50 Copay, Deductible, then coinsurance
Emergency Room Facility Charges*	$150 Copay	$150 Copay
Inpatient Facility Charges	Deductible, coinsurance	Deductible, coinsurance
Outpatient Facility and Surgical Charges	Deductible, coinsurance	Deductible, coinsurance
Mental Health		
Inpatient	Deductible, coinsurance	Deductible, coinsurance
Outpatient	Deductible, coinsurance	Deductible, coinsurance
Substance Abuse		
Inpatient	Deductible, coinsurance	Deductible, coinsurance
Outpatient	Deductible, coinsurance	Deductible, coinsurance

Medical and Pharmacy		
Benefits Coverage	In-Network Benefits	Out-of-Network Benefits
Other Services		
Chiropractic	$35 Copay	Deductible, coinsurance
Outpatient Orthopedic Surgery with Holista	Holista Bundle – No Cost Without Holista Bundle – Deductilble, coinsursance	Deductible, coinsurance
Outpatient Orthopedic Surgery with Door County Medical Center	Door County Medical Center Bundles- No Cost Bundle Care availble on: Total Knee Replacement, Total Hip Replacement, Carpal Tunnel Surgery, or Knee Arthroscopy	Not Covered
Birthing Services at Door County Medical Center	Birthing Bundle and Baby Swaddle- No out-of-pocket costs for delivery or newborn services at Door County Medical Center	Not Covered
Retail Pharmacy (up to 34 Day Supply)		
Generic (Tier 1)	$5	Not covered
Preferred (Tier 2)	$30	Not covered
Non-Preferred (Tier 3)	$60	Not covered
Preferred Specialty (Tier 4)	30%	Not covered
Mail Order Pharmacy (90 Day Supply)		
Generic (Tier 1)	$10	Not covered
Preferred (Tier 2)	$60	Not covered
Non-Preferred (Tier 3)	$120	Not covered
Preferred Specialty (Tier 4)	N/A	Not covered

Employee Contributions (Monthly)		
Medical		
	Monthly Rates With Wellness Incentive	**Monthly Rates Without Wellness Incentive**
Employee	$107.00	$178.33
Employee + Family	$267.37	$445.62

Door County Memorial offers to the employees of County of Door and their eligible plan participants, several no cost opportunities for care. These include Primary Care Visits, labs, x-rays, PT, Occupational Therapy, MRI/Xray (Facility Charge Only), Birthing Bundle, Baby Swaddle and Orthopedic Bundles of Care

SmithRx Prescription Drugs

Effective January 1, 2026, County of Door will no longer be covering GLP1's, Tirzepatides or any other weight loss medications solely being used for weight loss. This includes Zepbound, Weygovy, Ozempic, Monjaro and any other drug in its sole form or compounded. You must have a diagnosis of Type 2 diabetes to be eligible for coverage under the County of Door Health Plan. Coverage will continue to require prior authorization from Smith Rx which your doctor will need to participate in.

Get Ready to Use Your New Pharmacy Benefits

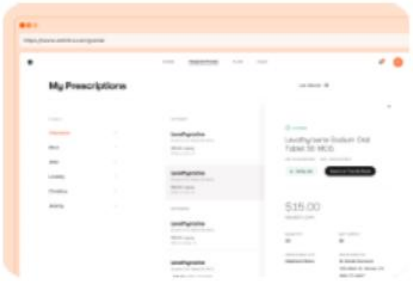
Get started with SmithRx in 3 easy steps!

1. **Update your Rx insurance with your pharmacy**

   You will soon receive a new benefits ID card, which will have your SmithRx plan information. Be sure to provide the pharmacy with this new card before filling your medication. The BIN, PCN, & group ID allows your pharmacy to find SmithRx in their system.

2. **Sign up for the Member Portal**

   Once your plan is active, you will have access to the SmithRx Member Portal. Here, you can view your plan details, find your medications for the lowest price at a pharmacy near you, view your prior authorization status, and more.



3. **Connect with Us for More Savings**

   At SmithRx, our mission is to help you save money on your medications. If you have a prescription eligible for savings, our Connect Team will reach out to you via phone, text, email and a notification in your Member Portal.

Simply connect with a Patient Access Specialist to start saving!

Refilling your Prescriptions with Ease

Retail Pharmacy Network

SmithRx partners over 65,000 retail pharmacies across the nation, including major national chains, regional chains, grocers and independent pharmacies. So chances are, you can keep using your current pharmacy. Here are just a few of the retail pharmacies in our network.

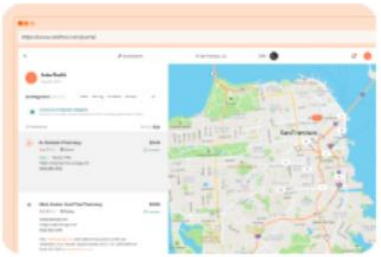
Mail Order Pharmacies

Take advantage of the cost savings and convenience of mail order services through our preferred partners:

Specialty Pharmacy Network

Costco Specialty Pharmacy and Senderra are available to fill your specialty medications.

Tip: Use the "Find My Meds" tool in the SmithRx Member Portal to locate pharmacies offering the lowest medication prices under your plan.



What is a Pharmacy Benefits Manager (PBM)?

Pharmacy benefits managers (or PBMs) like SmithRx administer prescription drug benefits on behalf of your employer's benefits plan. Your PBM powers your pharmacy experience by:

- Making sure you're charged the correct copay at the pharmacy
- Setting up and approving your medications to be covered according to your plan design
- Reviewing clinical requirements related to your prescriptions

What Can I Do in the SmithRx Member Portal?

- Find the lowest-cost pharmacy near you with "Find My Meds"
- View your plan and summary of benefits
- Look up prescription details
- See your prior authorization status in the notifications center
- Access your SmithRx Member ID Card
- Get prescription savings alerts

What is a formulary?

A formulary is a list of brand-name and generic medications that are covered by your benefit plan. Formularies vary by plan. SmithRx regularly reviews this list based on clinical guidelines, safety, effectiveness, and cost. Being on the formulary doesn't guarantee coverage, and the list may change over time.

Where can I find the drug formulary?

You can access your plan's drug formulary by visiting the SmithRx member portal at smithrx.com/members. Please note that your plan benefits may also have coverage restrictions that may not be represented on the drug formulary.

What if my medication is not in the formulary?

The formulary lists medications in many therapeutic areas. If your medication is not covered, there may be a lower cost alternative available. If you have explored all other alternatives, your doctor may be able to seek an exception based on medical necessity. Please contact SmithRx Member Support to assist with finding alternatives if your medication is not listed in the formulary.

My medication needs prior authorization. What does this mean?

A prior authorization (PA) is a review your plan requires for certain medications. If a PA is required, your doctor will submit the request to SmithRx—no action is usually required from you. While our team aims to act promptly, it can take up to 15 days to receive a response on non-urgent PA's and up to 72 hours for urgent cases. You'll get a decision by mail. For text updates, add your mobile number in the member portal or contact Member Support at smithrx.com, help@smithrx.com, or (844) 454-5201. You can also get timely notifications and track your PA process through the Member Portal.

To check if your medication needs a PA, log into the SmithRx Member Portal and use "Find My Meds".

What is Step Therapy?

In some cases, your plan requires you to first try one medication for your condition before it will cover another medication. This is most common if there is a generic medication available. You can identify which drugs require step therapy by using the formulary lookup tool on the member portal.

SmithRx Member Support

The SmithRx Member services team is dedicated to ensuring you understand your plan and can access your medications with ease.

Live assistance is available **Monday through Friday, 8 am - 9 pm ET** and **Saturdays 11 am - 4 pm ET**.

Chat
Chat live with a member service representative on our website or in the member portal

Portal
Find plan information and documents at smithrx.com/portal

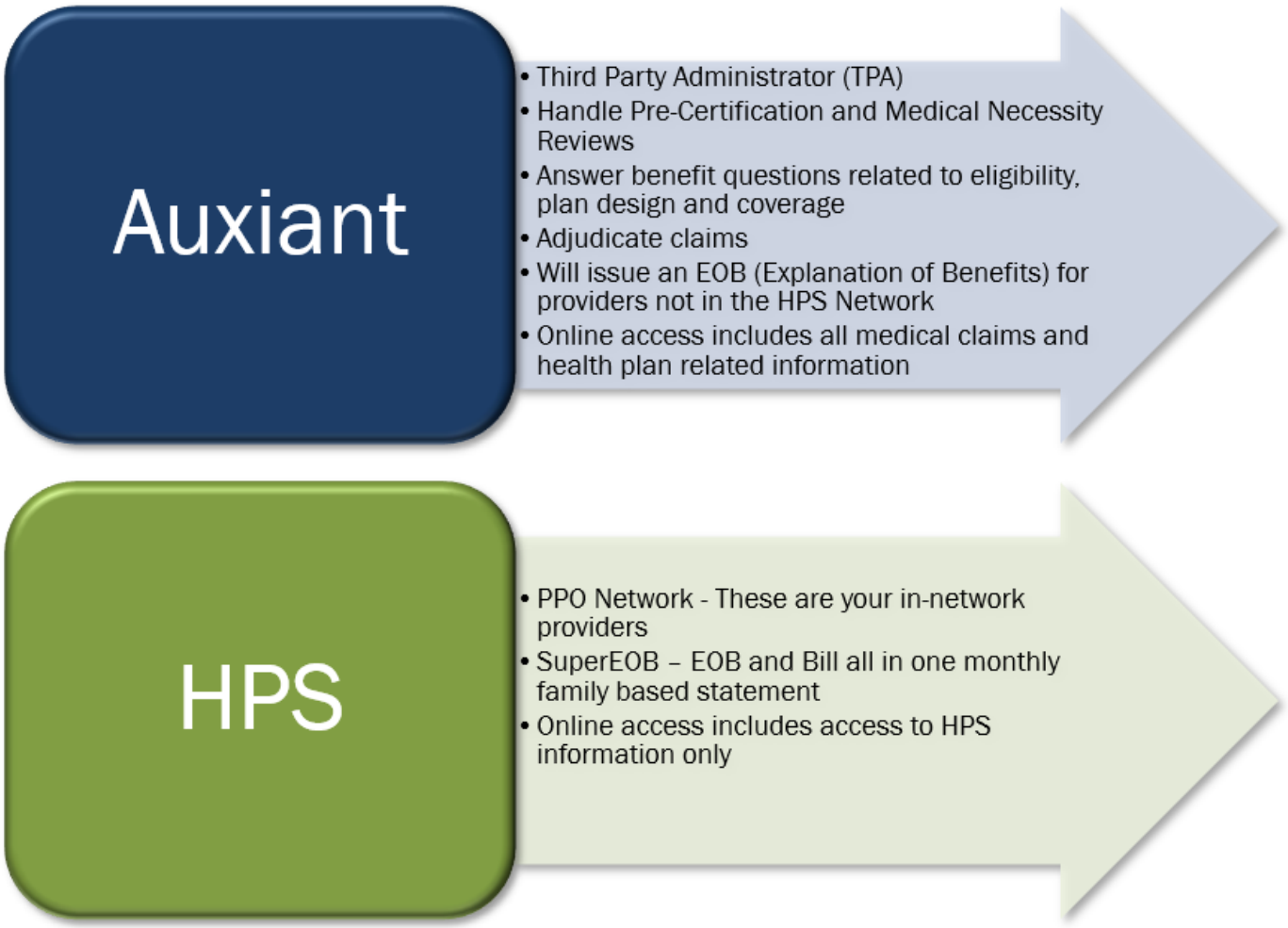
Email
Email our team at help@smithrx.com

Phone
Call us at 844-454-5201

Connect Support Team

For assistance with **savings program enrollment**, contact our dedicated support team at 844- 385-7612 or connect@smithrx.com.

Auxiant vs. HPS (Health Payment Systems)



Auxiant


Auxiant®
VISIT US ON THE WEB
auxiant.com
With AuxiantHealth you can:
Link to network providers
Contact customer service through Auxiant Live Chat
View enrollment and claim information, print EOB's, and track claims
View deductibles and out-of-pocket amounts
Access plan documents and amendments
Link to Prescription Benefit Manager
Get information on the go via our mobile app
Welcome, Joe Smithington
At Auxiant.com you have 24/7 access to your personal health care account information
Questions? Contact Auxiant at 1.800.279.6772
Live chat with Auxiant customer service, click Online Chat to begin
Auxiant

Health Payment Systems (HPS) Network

HPS Member Portal

Access the portal anytime at https://onlineaccess.hps.md/

- ✓ **Make payments securely**
- ✓ **View statements and claim-level details**
- ✓ **Search for in-network providers**
- ✓ **Access FAQs and other resources**

Register for online access

Once you receive a SuperEOB, you can register for an HPS Online Access account. You will need:

- ✓ **Group number (from the HPS ID card you received by mail)**
- ✓ **Member's date of birth**
- ✓ **Last four digits of the member's Social Security Number**
- ✓ **Statement Number (in the upper-right hand corner of the SuperEOB)**

The HPS Network

The most effective independent provider network in Eastern Wisconsin

- ✓ **No upfront payments to Provider**
- ✓ **Present your most recent ID card**

The SuperEOB

HPS pays your medical out of pocket expenses to the providers, then sends you one monthly consolidated statement, The SuperEOB, which includes:

- ✓ **An account summary with the total amount due for all in network claims**
- ✓ **Claims details for new charges**
- ✓ **How to pay your claims: mail, phone, or online options**
- ✓ **Payment plans available with 0% interest: call 888.477.7968**

Garner HRA

Garner, your free healthcare benefit

garner™

What is Garner?

Garner is a free healthcare benefit offered by your employer.
It's free to use at no cost to you.

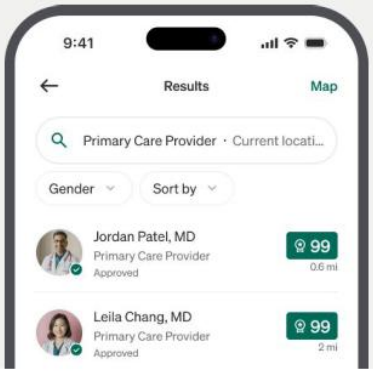
Garner helps you find the best doctors near you

Get money back on your medical bills **up to your benefit amount** for you and your family

Follow the steps below to get reimbursed.

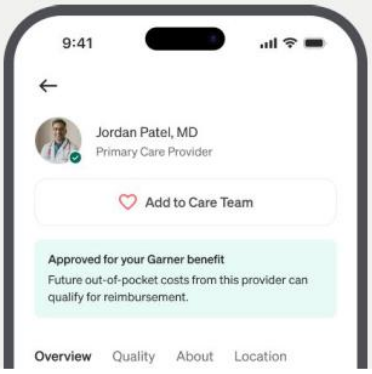
01

Search for top doctors in the Garner app



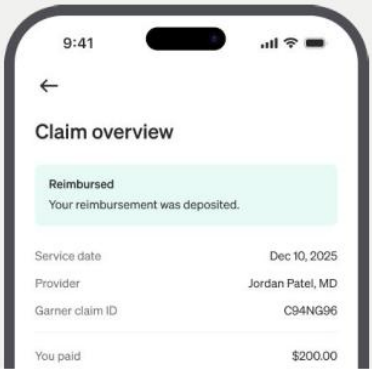
02

Add doctors to your Care Team before your visit



03

Get reimbursed for your out-of-pocket medical bills



Get reimbursed up to your benefit amount for you and your family.

Scan the QR code to create an account

garner.guide/create-my-account

Need our help?

You can contact our Concierge team via in-app chat or concierge@getgarner.com, Monday-Friday, 8:00 a.m. to 10:00 p.m. ET after creating an account.

Top Provider Methodology Overview

garner™

Garner Health makes it easy to find and visit the best doctors near you. Using one of the largest medical claims databases in the country and revolutionary data science, we measure the performance of individual providers to recommend the ones that help their patients stay healthier and recover more quickly. On average, Garner Top Providers help their patients enjoy **3 additional healthy days per year.**

Here's what we consider when making our recommendations:

1. **Quality:** doctors who follow best practices supported by medical literature
2. **Reviews:** doctors with positive patient reviews
3. **Cost:** doctors who refrain from excessive utilization of wasteful services
4. **Distance:** doctors within a reasonable distance from you

Garner's methodology provides the most comprehensive measurement of physician quality available.

Garner's Specialty-Specific Approach

1 Comprehensive Dataset

We built one of the nation's largest medical claims databases, including 60 billion medical claims from 310 million patients, covering 98% of providers.

2 Reliable Metrics

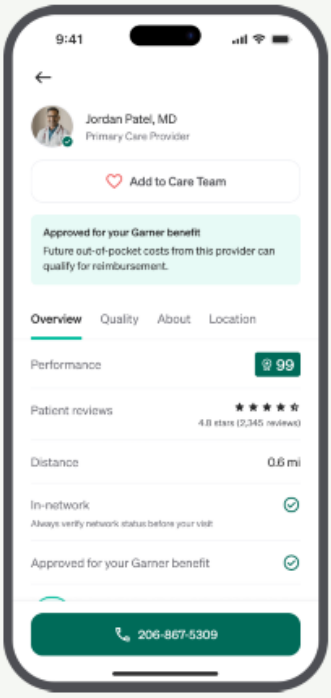
We measure provider quality using 550 speciality-specific metrics developed by our Clinical Advisory Board and data science team, which are reviewed regularly to ensure they reflect the latest medical research.

3 Sophisticated Analytics

We analyze metrics from individual medical claims, providing greater transparency and precision than traditional "grouper" methods.

4 Holistic View of All Physician Decisions

We provide an unbiased assessment and address variations in hospital systems by evaluating individual physicians using metrics on care quality, prescribing patterns, and patient outcomes.

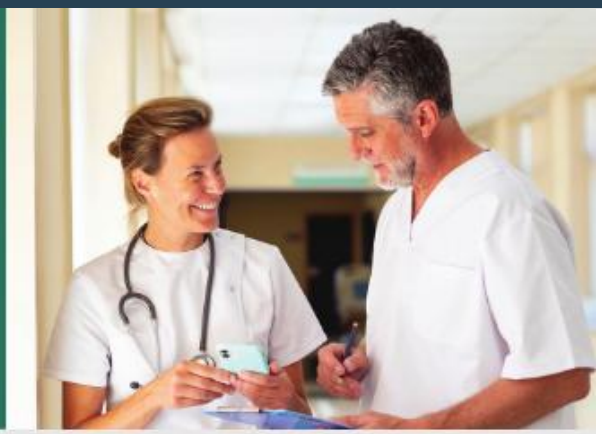


Scan the QR Code with your mobile phone to get started

Or visit **Garner.Guide/Start** to sign up for an account. When creating your account, make sure to use **your full legal name.**

To learn more about Garner's Top Provider methodology, visit: app.getgarner.com/methodology

How Garner identifies Top Providers



> **At Garner, we believe that choosing the right doctor is one of the most important decisions you can make for your health — and we're here to help.**

Garner identifies Top Providers by analyzing one of the largest medical claims databases in the U.S. — that's more than 60 billion medical records representing more than 310 million patients.

Garner's team of doctors and data scientists evaluate doctors using hundreds of metrics to pinpoint the best ones so you get the best possible care.

We assess each provider based on specific metrics related to their specialties such as:

Complication rate

Measure a doctor's complication rates

Invasive procedure rate

Determine if a doctor performs more invasive procedures only when necessary given they entail longer recovery times and complication risks

Follows current medical guidelines

Evaluate if a doctor recommends optimal treatment according to medical guidelines

Why people like you choose Garner

Meet Mary

"Garner allows me to afford the things that are medically necessary. It's a huge benefit at this company."

$2,230
reimbursed with Garner

Meet Mark

"When I go see a doctor, I see a Garner doctor. It's too easy not to."

$2,520
reimbursed with Garner

How reimbursement works

A Garner member used the Garner app to search for a "hip and knee orthopedic surgeon" and saw Dr. G for a knee replacement surgery

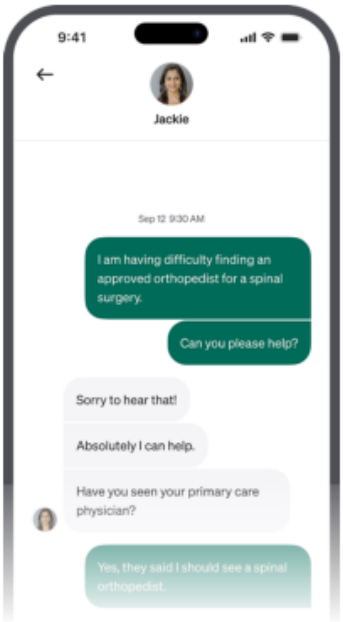
Cost of knee replacement	$17,075
Cost covered by insurance	$15,675
Garner reimbursement	$1,400
Total cost to member	**$0**

Have questions or need help?

Contact the Garner Concierge Team. The Concierge is available Monday to Friday, 8:00 a. m. to 10:00 p. m. ET, in both English and Spanish.

Message the Concierge via:

- Garner Health App
- concierge@getgarner.com
- 866-761-9586

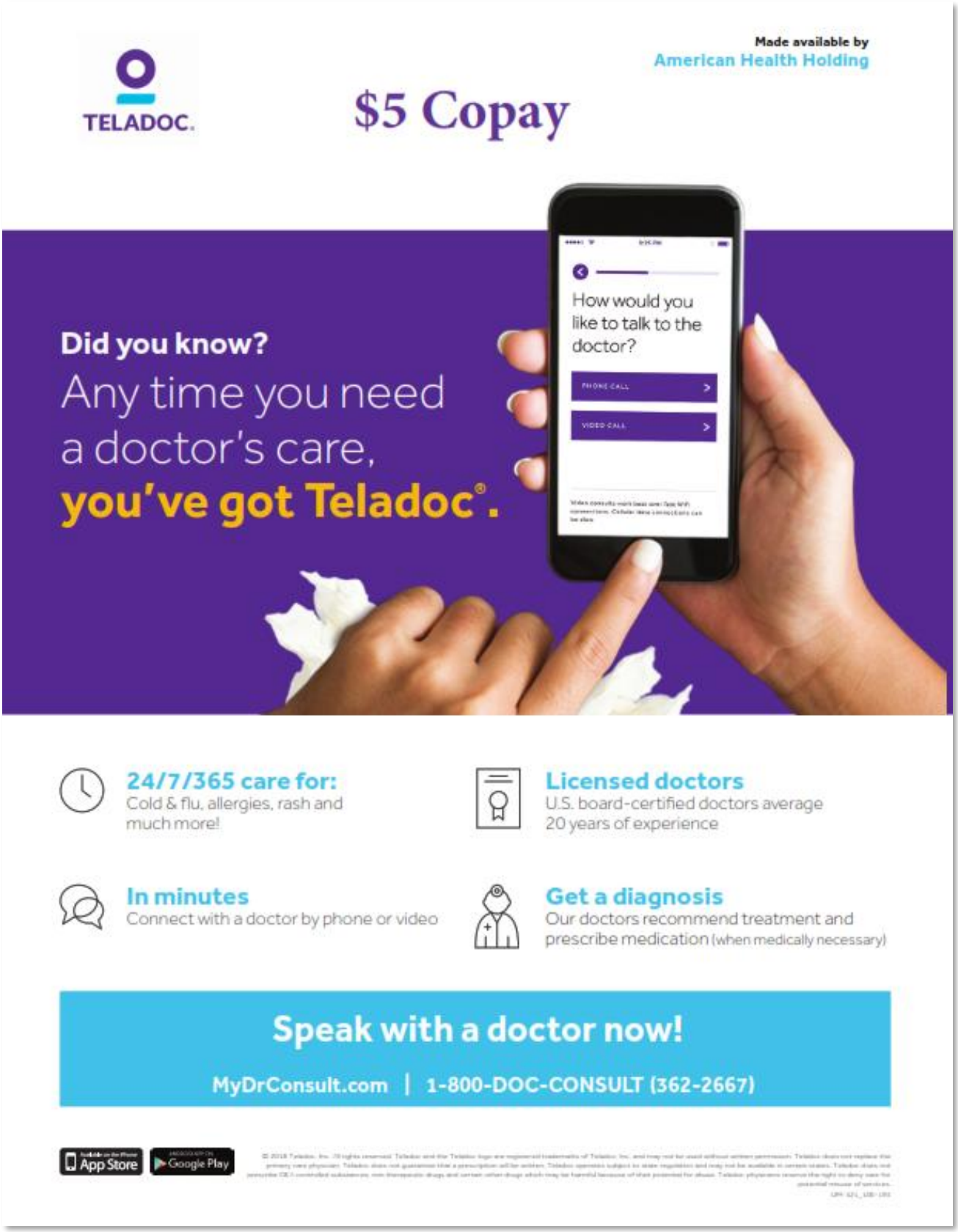


Teladoc

Teledoc is available 24/7 to all employees and their families covered on the County of Door health plan.

Scan QR code below to learn more about telehealth.

Teladoc


TELADOC.
Made available by
American Health Holding
$5 Copay
Did you know?
Any time you need a doctor's care, you've got Teladoc®.
How would you like to talk to the doctor?
PHONE CALL
VIDEO CALL
24/7/365 care for:
Cold & flu, allergies, rash and much more!
Licensed doctors
U.S. board-certified doctors average 20 years of experience
In minutes
Connect with a doctor by phone or video
Get a diagnosis
Our doctors recommend treatment and prescribe medication (when medically necessary)
Speak with a doctor now!
MyDrConsult.com | 1-800-DOC-CONSULT (362-2667)
App Store
Google Play

Holista

Your health plan includes access to the HPS Episodes of Care Program, in partnership with Holista. All orthopedic surgeries/services scheduled through Holista qualifies for Holista bundled pricing, saving you and the health plan on out-of-pocket costs! All your out-of-pocket costs are waived if you schedule through Holista!

Your health plan includes access to the HPS Episodes of Care Program, in partnership with Holista.

HOLISTA hps | PayMedix

Heading for Surgery? Here's how to Pick the Best Option.

Working with your Primary Care Doctor is important, especially when your journey leads to surgery. However not all surgeons are created equal. Did you know some of the best, highest quality doctors actually charge less? That's right. When a surgeon is top of their field, they need less anesthesia, fewer nurses, and less time in the operating room.

855-240-9430

Next time your doctor recommends surgery call HPS Episodes of Care to see if your procedure qualifies for a Holista bundle.

Contact us at 855-240-9430.

Most common bundles:

- Achilles Repair
- ACL /MCL Repair
- Knee Replacement
- Bunionectomy
- Carpal Tunnel Release
- Total Shoulder Replacement
- Rotator Cuff Repair

Scan for a Complete List of Services

Holista Episodes of Care: How they can benefit YOU

One price. One easy-to-understand bill. Total transparency.

For each episode of care, you will receive the highest level of benefit from your employer, allowing the lowest out-of-pocket cost.

Personalized care. Ongoing support.

A dedicated care coordinator will be right by your side to guide you through your entire care journey. When you need extra assistance, or have any specific medical questions, a Registered Nurse is available for support.

Improved quality of care. Lower costs.

Holista improves your quality of care and saves you money by packaging, or bundling, healthcare into "episodes."

Convenience - both online and off.

Access your online patient portal to view your personalized care plan, get your ID card, read educational materials and receive immediate support.

Savings Examples* –

Common Services	Typical Cost	Bundle Cost	Total Savings
Achilles Repair	$18,927	$8,349	$10,578
Carpal Tunnel Release (In office)	$7,488	$4,400	$3,088
Total Knee Replacement	$42,120	$30,200	$11,920

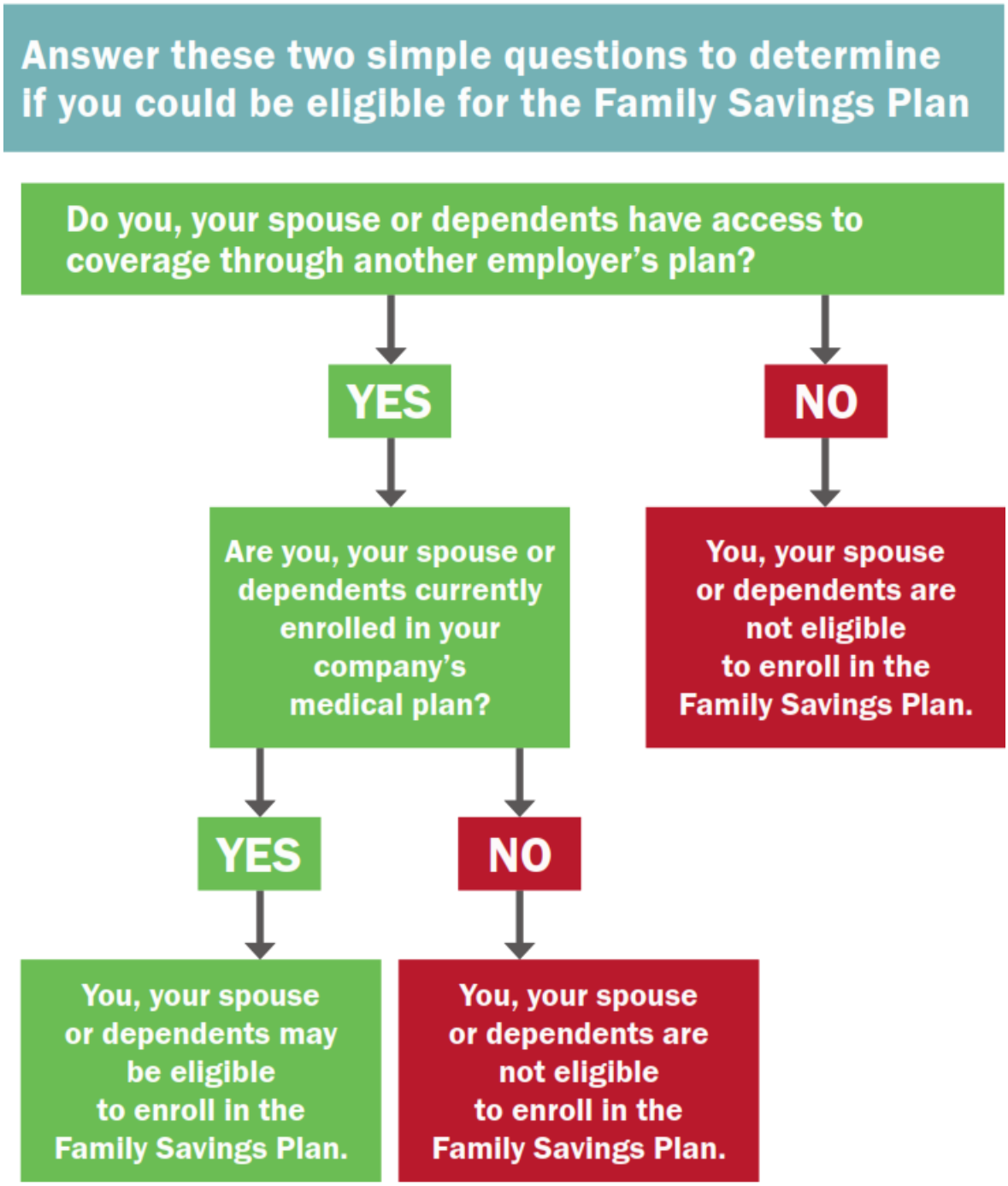
* Savings Examples – Prices can vary by location

Family Savings Plan (Network Health)

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

How it works

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



The premium differential, should your cost to move to your spouse's employers' plan, will be $150.00 per month, regardless of whether you were enrolled in a Single or a Family Plan with County of Door. This amount is considered taxable income and will be paid to the employee.

Door County Medical Center Care

Your health plan includes access to Door County Medical Center Primary Care Physicians (PCP) at no cost to you when you see a PCP provider through any of their clinic, urgent care, or DirectCare locations including Algoma, Sturgeon Bay, Sister Bay, and Washington Island. Primary Care is defined as Family Practice, Internal Medicine, OB/GYN, or Pediatricians.

What is covered/not covered under this program?

- Services limited to problem-focused PCP visits
- Preventive visits

Any tests ordered or procedures performed will be billed and adjudicated through the County of Door's medical plan.

Personal Health Team - FAQs

- **What is Personal Health Team?**
  Personal Health Team is a primary care model where your employer has paid in advance for your office visits to Door County Medical Center primary care providers and locations. That means that if you have a medical or preventive healthcare need, you can be seen without a copayment at any of our primary care locations.

- **Which healthcare providers can I see under this program?**
  Any Family Practice, Internal Medicine, OB/Gyn, or Pediatrician at any of our clinic, urgent care, or *DirectCare* locations are covered under this program. We currently offer primary care in Algoma, Sturgeon Bay, Sister Bay, and on Washington Island.

- **So my healthcare in the clinic is completely free?**
  It is important to note that your employer has paid for all of your office visits in advance, which will ensure that you do not have a copayment for those visits. However, if tests are ordered or other procedures are performed, those will be billed to your insurance and standard coinsurance and deductibles will apply for those services.

- **Are my dependents covered under this program?**
  Yes! Your employer has paid for all members on the company's health insurance plan to be covered under this program.

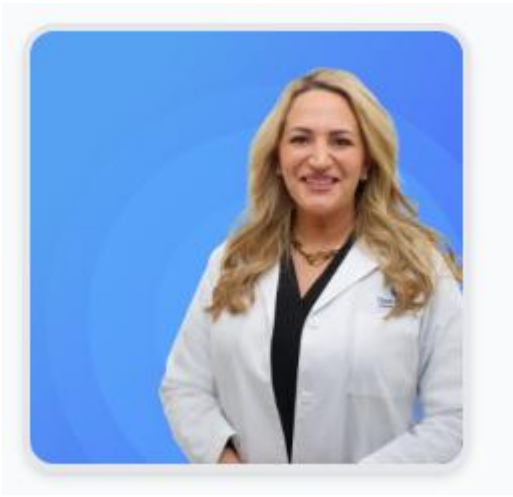
- **Why is my employer doing this?**
  For you and your family, this program will provide unlimited access to primary care providers at Door County Medical Center locations. In doing so, we trust that you will form a closer relationship with your primary care provider and seek treatment sooner for small problems, before they become big problems. Your employer benefits by paying less for primary care. In bypassing the insurance claims process for office visits, your employer can essentially buy caregiver time more affordably on behalf of you and your family. We at Door County Medical Center also benefit from this arrangement, in that billing and collecting office visit claims is expensive and time consuming. With this direct arrangement, we can save money and cut healthcare expenses for everyone in the community. This is truly a win-win-win!

Your health plan includes access to no-cost birthing services and orthopedic procedures at Door County Medical Center.

Door County Medical Center and County of Door have teamed up to offer you access to ZERO COST healthcare procedures.

Door County Medical Center is one of the top critical access hospitals in the nation. More than a hospital, Door County Medical Center is an integrated health system providing the residents of Door and Kewaunee Counties with state-of-the-art technology and procedures.

Door County Medical Center
IN PARTNERSHIP WITH HOSPITAL SISTERS HEALTH SYSTEM



Bundle Care Available:

- Birthing Bundle
- Baby Swaddle
- Total Knee Replacement
- Total Hip Replacement
- Carpal Tunnel Surgery
- Knee Arthroscopy

Expanded PHT Program for 2026:

- Labs
- Physical Therapy
- Occupational Therapy
- MRI/ XRAY (Facility Charge Only)

Call for an orthopedic appointment:

(920)746-0510

Dental

County of Door offers a dental program. The chart below is a brief outline of the plan. Please refer to the summary plan description for complete plan details.

Delta Dental of Wisconsin Inc. Dental		
Benefit Coverage	In-Network Benefits	Out-of-Network Benefits
Annual Deductible		
Individual	$0	$0
Family	$0	$0
Annual Maximum		
Per Person / Family	$1,000	$1,000
Preventive	100%	100%
Basic	100%	100%
Major	50%	50%
Orthodontia		
Benefit Percentage	50%	50%
Adults (and Covered Full-Time Students, if Eligible)	Not covered	Not covered
Dependent Child(ren) To age 19	Covered	Covered
Lifetime Maximum	$1,200	$1,200

Network Options

Delta Dental offers a choice of two different types of network providers: PPO and Premier. The PPO network is a smaller list of dentists that have agreed to the greatest discounts for dental services. The Premier network includes the most dental providers who have agreed to discounts for Delta Dental members, though the discounts are less than those in the PPO network. To identify an in-network provider go to www.deltadentalwi.com.

When accessing care out of network, there are no provider discounts, and the member is responsible for the difference between what is charged/billed over the Usual and Customary percentile.

INFORMATION ON THE GO!

Access your dental account information from your smartphone or mobile device with Delta Dental's app. With this app, you can:

- View your summary of benefits or claims
- Access your ID card
- Find a network dentist

DELTA DENTAL

Smarter Dental Plans

Evidence-Based Integrated Care Plan (EBICP)

Delta Dental of Wisconsin's Evidence-Based Integrated Care Plan (EBICP) provides **extra benefits for individuals with certain medical conditions** that have oral health implications. Research has shown that increased frequency of cleanings and topical fluoride applications greatly impact oral health, and sometimes play a role in managing conditions such as:

Cancer therapy

Oral health tends to be a difficult challenge for some cancer patients. Oral pain, gum infections, rapid tooth decay, and dry mouth are among the side effects associated with radiation and chemotherapy.**

Periodontal disease

Studies have shown that a greater frequency of maintenance can reduce the need for repeating periodontal (gum) surgery.**

Diabetes

Evidence has shown a higher presense of periodontal disease in individuals with diabetes.*

Pregnancy

Pregnant women are more likely to get periodontal disease. It is beneficial for pregnant women to maintain good oral health.*

High-risk cardiac conditions

Maintaining good oral health and eliminating oral disease decreases a cardiac-risk patient's chances of contracting Infective Endocarditis (IE), a disease where bacteria infect in the tissues of the heart.*

Weakened immune systems

Oral complications can increase both treatment costs and disease rates in individuals with weakened immune systems. Even common conditions like dry mouth and dental decay can be indicators of more serious problems. Associated medical conditions can include rheumatoid arthritis, lupus, multiple sclerosis, Crohn's disease and more.**

Kidney failure or dialysis

Studies have shown that individuals with kidney disease have a higher likelihood of periodontal disease and tooth loss, and that the severity of these oral health issues is typically related to the level of kidney dysfunction.*

Connect With Us

www.deltadentalwi.com

SS300A-1901

*additional cleanings

**additional cleanings and topical fluoride treatments

DELTA DENTAL

Smarter Dental Plans

Enhanced dental benefits for those who need them most.

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

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

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

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

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

how to enroll

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

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

Connect With Us

www.deltadentalwi.com

SS300H-1905

Amplifon Hearing Health Care Discount Program

Delta Dental provides a hearing care discount program through Amplifon Hearing Health Care for you and your family members regardless of if you are covered on the dental plan.

Vision Insurance

County of Door offers a Vision Program through Superior Vision

Plan Feature	Frequency	In-Network	Out-of-Network
Network			
Examination	1 in 12 months	No Charge	Reimbursement up to $35
Standard Lenses Single Vision Lined Bifocal Lined Trifocal Lenticular	1 in 12 months	No Charge	 Reimbursement up to $25 Reimbursement up to $40 Reimbursement up to $45 Reimbursement up to $80
Frames	1 in 24 months	$150 frame allowance	Reimbursement up to $75
Contact lenses in leu of eyeglasses *(Contacted lenses fitted, evaluation and follow-up are covered in lieu of eyeglass lenses and frames benefit)*	1 in 12 months	175 retail allowance	Reimbursement up to $150
Medically Necessary	1 in 12 months	No charge	Reimbursement up to $150
Lasik Vision Correction		$200 allowance	

Discount Features

Non-Covered Eyewear Discount: Members may also receive a discount of 20% from a participating provider's usual and customary fees for eyewear purchases which exceed the benefit coverage (except disposable contact lenses, for which no discount applies). This includes eyeglass frames which exceed the selected benefit coverage, specialty lenses (i.e. progressives) and lens "extras" such as tints and coatings. Eyewear purchased from a Walmart Vision Center does not qualify for this additional discount because of Walmart's "Always Low Prices" policy.

Employee Contributions (Monthly)	
Vision	
Employee	$8.20
Employee & Spouse	$16.94
Employee & Child(ren)	$19.20
Employee & Spouse & Child(ren) (Family)	$29.66

Flexible Spending Accounts

The Flexible Spending Account (FSA) plans allow you to set aside pre-tax dollars to cover qualified expenses you would normally pay out of your pocket with post-tax dollars. The plan is comprised of a health care spending account and a dependent care account. You pay no federal or state income taxes on the money you place in an FSA. The FSA plans are administered through Diversified Benefit Services.

Health Care FSA

A Health Care FSA allows you to pay for unreimbursed health care expenses for you, your spouse and dependent children. You do not need to be on your employer sponsored health plan to sign up for an FSA.

Examples of eligible health care expenses Include:

- Medical Plan Deductibles
- Co-Pays
- Dental Expenses (Including Orthodontics)
- Eye Exams, Glasses and Contacts

This plan includes a 2 ½ month grace period. A grace period allows you to submit eligible claims through March 15, 2026.

One of the biggest advantages of the Health Care FSA is that you can access your entire elected amount on the first day of the plan year. So, there's no need to wait until funds have been payroll deducted to use your FSA.

As you plan your FSA expenses for the year, it is important that you make accurate and conservative estimates.

The annual maximum amount you may contribute to the Health Care FSA in 2026 is $3,400.

Health Care reimbursement election amounts are only allowed to be changed on January 1st unless you have a qualifying event.

Dependent Care FSA

A Dependent Care FSA allows you to pay for child or elder care expenses using tax-free dollars. These expenses must be incurred while you are employed and must be for the care of a qualified dependent.

Examples of Eligible Dependent Care Expenses Include:

- Pre-School Charges
- Before-and After-School Care
- Day Care Centers
- Summer Day Camps
- And More

Unlike the Health Care FSA, Dependent Care FSA funds are not available to you on day one. These funds must accumulate before you can reimburse yourself, and you can only be reimbursed up to the amount you have in the account at any given time.

The annual maximum amount you may contribute to the Dependent Care FSA is $7,500 (or $3,750 if married or filing separately) per calendar year.

Dependent Care election amounts can be changed during the year as cost changes.

Flex Debit Card (Benny Card)

The Benny Card allows you to pay for your healthcare needs on the spot at qualified locations without having to wait for a reimbursement check. The card can be used at hospitals, physician offices, dental offices, vision service providers and pharmacies. With the use of the Benny Card, most claims are verified electronically; however, there may be some claims that require additional verification, so it is very important to save your payment receipts. Diversified Benefit Services will reach out to you directly if you need to submit receipts.

Flex Debit Card Advantage

- Payment comes directly from your Health Care FSA account, which reduces your out-of-pocket expense
- Limits the need to submit claim forms and wait for reimbursement
- FSA plan year is January 1st through December 31st.
- Any changes in election (other than January 1st) can only happen if there is a family status change (Marriage, Divorce, Birth or Death) In order for the employee's child's claims to be paid, the child must be dependent of the employee by IRS.

Important rules to keep in mind:

- The IRS has a strict "use it or lose it" rule. If you do not use the full amount in your FSA, you will lose any remaining funds.
- Once you enroll in the FSA, you cannot change your contribution amount during the year unless you experience a qualifying life event.
- You cannot transfer funds from one FSA to another.

Please plan your FSA contributions carefully, as any funds not used by the end of the year will be forfeited. Re-enrollment is required each year.

Note: Your Benny Card is good for 5 years. You will not automatically receive a new card each year so DO NOT THROW YOUR BENNY CARD AWAY. Fees may apply to receive a replacement card.

ENHANCED DBS MOBILE APP

There's no easier way to submit claims and review account information than with the latest version of our mobile app. Day or night, you have convenient and secure access to account activity from your mobile phone.

NEW APP FEATURES:

- View account balances
- Submit new claims and view claim status
- Submit supporting documentation
- Manage debit card transactions
- Create a new account or reset your password

Download the updated app to begin using the new features today!

GET IT ON Google Play

Download on the App Store

P.O. Box 260 Hartland, WI 53029
Toll Free: (800) 234-1229
Phone: (262) 367-3300
DBSbenefits.com

DIVERSIFIED BENEFIT SERVICES, INC.

County of Door's Wellness Initiatives

As healthcare costs continue to rise, we strive to offer competitive health benefits to take care of you and your family. A successful wellness program is a win-win — it means our employees are improving their lives, and we are one step closer to managing rising health insurance costs.

Door County's wellness program helps you proactively engage in your health to help you discover and manage any medical conditions you may have. The wellness program incentivizes participants for connecting with a primary care physician (PCP) and being compliant with suggested age/gender screenings. Connecting individuals with a PCP promotes screenings and early detection, identification of undiagnosed conditions, and management of chronic conditions. Early diagnosis may mean increased survival rates and quality of life alongside decreased financial burdens relating to a condition.

County of Door Responsibilities

The County of Door will not collect any individual results. The County only needs the completed Physician Results and Preventive Screening forms to know the requirement is met to earn the incentive, so the County is able to issue the incentive accordingly.

Your Responsibilities

1) You must complete an annual biometric screening.
2) Complete one preventive screening.

Provide your physician with the Physician Results and Preventive Screening Forms to complete. Submit the completed forms to Human Resources- Benefits Team by either interoffice to Michelle, email: mpaschke@co.door.wi.us, or fax: (920)746-2538.

Incentives

To qualify for the incentive all Physician Results Forms and Preventive Screening Forms must be completed by October 31, 2026 and submitted to Human Resources- Benefits Team no later than November 15, 2026.

Employee Assistance Program

County of Door believes our employees are our most valuable resource. For this reason, we provide an Employee Assistance Program (EAP) at no cost to you. Advocate Aurora EAP is a confidential resource available to help employees and their family members resolve personal or work-related challenges. Employees and their household family members are eligible for confidential counseling (up to 3 free in-sessions per issue, per year) through the Employee Assistance Program. Types of issues addressed by our EAP include:

- Alcohol/drug abuse
- Anxiety or depression
- Balancing work & family
- Caring for aging parents
- Child/family concerns
- Finding quality and cost-effective childcare
- Divorce
- Financial pressures
- Legal issues
- Relationship issues
- Workplace stress

Advocate Aurora EAP can be contacted confidentially via telephone at 800-236-3231. To learn more about Advocate Aurora EAP, visit www.aah.org/eap.

Contacts

Have Questions? Need Help?

Please contact Human Resources to complete any changes to your benefits that are not related to your initial or annual enrollment.

Carrier Customer Service

BENEFITS PLAN	CARRIER	PHONE NUMBER	WEBSITE
Medical PPO	Auxiant	800-279-6772	www.auxiant.com
Garner Medical Benefits	Garner	Concierge: 866-761-9586	Email: concierge@getgarner.com
Pharmacy	SmithRx	844-454-5201 help@smithrx.com	www.smithrx.com
Dental PPO	Delta Dental of Wisconsin Inc.	888-324-8000	www.deltadentalwi.com
Vision	Superior Vision/Versant Health	800-507-3800	www.superiorvision.com
Flexible Spending Account	Diversified Benefit Services, Inc.	800-234-1229	www.dbsbenefits.com
Wellness Program	County of Door	920-746-2539 mpaschke@co.door.wi.us	

REQUIRED NOTIFICATIONS

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: $2,500 Ded. Ind./$5,000 Ded. Family, $3,500 Coinsurance Ind./$7,000 Coinsurance Family

NEWBORNS ACT DISCLOSURE − FEDERAL

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 SPECIAL ENROLLMENT RIGHTS

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

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

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.
No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan reviewed and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Michelle Paschke
421 Nebraska Street
Sturgeon Bay Wisconsin 54235
920-746-2539
mpaschke@co.door.wi.us

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***Please review it carefully****.*
Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

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

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/hipaa/filing-a-complaint/index.html.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

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

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

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

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

Changes to the Terms of this Notice

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

Other Instructions for Notice

- 10/16/2024
- Michelle Paschke, mpaschke@co.door.wi.us, 920-746-2539

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE FOR USE ON OR AFTER APRIL 1, 2011

Important Notice from County of Door 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 County of Door 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. County of Door has determined that the prescription drug coverage offered by the County of Door Health and Welfare Medical plan for the plan year 2025 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, the following options may apply:

- You may stay in the County of Door Health and Welfare Medical plan and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date without penalty either:
    - During the Medicare prescription drug annual enrollment period, or
    - If you lose County of Door Health and Welfare Medical plan creditable coverage.
- You may stay in the County of Door Health and Welfare Medical plan and also enroll in a Medicare prescription drug plan. The County of Door Health and Welfare Medical plan will be the primary payer for prescription drugs and Medicare Part D will become the secondary payer.
- You may decline coverage in the County of Door Health and Welfare Medical plan and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do not enroll in the County of Door Health and Welfare Medical plan you are not able to receive coverage through the plan unless and until you are eligible to reenroll in the plan at the next open enrollment period or due to a status change under the cafeteria plan or special enrollment event.

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 County of Door 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 County of Door 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:	10/16/2024
Name/Entity of Sender:	Michelle Paschke
Contact Position/Office:	Human Resources
Address:	421 Nebraska Street
Phone Number:	920-746-2539

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, 2024. Contact your State for more information on eligibility –

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

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/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

FLORIDA – Medicaid

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

GEORGIA – Medicaid

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

INDIANA – Medicaid

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)

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

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

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

LOUISIANA – Medicaid

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

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

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsphttps://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3739

MISSOURI – Medicaid

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

MONTANA – Medicaid

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

NEBRASKA – Medicaid

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

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

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

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html

CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

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

NORTH DAKOTA – Medicaid

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

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

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

PENNSYLVANIA – 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)

RHODE ISLAND – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

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
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since 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)
Menu Option 4, Ext. 61565

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
Error! Hyperlink reference not valid.1-877-267-2323,

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.

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

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 9.12%[1] 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 9.12% of the employee's household income.[2]

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 these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023, and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023, and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact:

Name of Entity/Sender:	County of Door / Michelle Paschke
Contact--Position/Office:	Human Resources
Address:	421 Nebraska Street
Phone Number:	920-746-2539

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer Name County of Door		4. Employer Identification Number (EIN) 39-6005686
5. Employer address 421 Nebraska St.		6. Employer phone number 920-746-2539
7. City Sturgeon Bay	8. State WI	9. ZIP code 54235
10. Who can we contact about employee health coverage at this job? Michelle Paschke		
11. Phone number (if different from above)	12. Email address mpaschke@co.door.wi.us	

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:
  - ☒ Some employees. Eligible employees are:
    Employees who meet the eligibility requirements for benefits
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:
    Spouses, dependent children to age 26
  - ☐ We do not offer coverage.

☒ 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. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

DOOR COUNTY

Michelle Paschke
421 Nebraska Street

Sturgeon Bay, Wisconsin 54235

This brochure summarizes the benefit plans that are available to County of Door eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits