2023 Benefits Summary

9 Month Employee

Note About Your Benefits

At Community Action of Eastern Iowa, we're committed to helping our employees maintain health and financial well-ness. Your benefits are an important part of your overall compensation and every effort has been made to offer a full range of benefits to protect you, your family, and your way of life!

What is Open Enrollment (In the Fall)?

Open enrollment is the only time of the year to make changes to your group health plan benefits. You can enroll, drop dependents, change plan options, etc. Changes made during Open Enrollment will be effective January 1, 2023. The only other time you can make changes outside open enrollment is when you experience a qualifying event (marriage, divorce, birth/adoption or death).

What's Inside

IMPORTANT MEDICARE NOTICE: 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 6 for Medicare Part D coverage information.

START PLANNING!

Enrollment Checklist:

1. Understand Your Choices— Review this benefits summary as well as any additional information provided to you. Keep this information handy so you can refer to it at any time throughout the year.

2. Review Your Options with Your Family— Make sure you include any other individuals who will be affected by your elections in the decision-making process.

3. Make Your Elections– You may elect benefits during your eligibility period or during open enrollment on our benefits enrollment site, Ease. If you plan to waive coverages, you must decline benefits. All enrollments should be done through Ease. Be on the look out for an email with a link to begin your enrollment on the site.

2023 BENEFITS OVERVIEW

Eligible Employees & Dependents

If you're a regular, full-time employee who is expected to work 30 hours or more per week, you're eligible to participate in benefits. Your legal spouse and dependent children are eligible for coverage. A dependent child includes:

- Biological children or step-children.
- Adopted children or children placed in your home while you are awaiting finalization of their adoption.
- Children for whom you have legal guardianship.
- Non-custodial children as required by a qualified medical child support order.
- Disabled children who depend on you for support and maintenance because of mental or physical handicap, regardless of age, if the disability occurred prior to age 26 and they have been continuously covered under the plan prior to and beyond age 26.

When Benefits Begin for New Hires

If you're new to CAEI, your benefits will begin on the first day of the month following 60 days of employment.

When Benefits End

The coverage you elect will end if you drop benefits during next year's open enrollment, you drop benefits due to a qualifying life event, or you terminate employment.

Pre-Tax Contributions

If elected, any medical, dental, and vision contributions you make for you and/or your tax-qualified dependents will be deducted from your pay on a pre-tax basis.

Choose Carefully!

Due to IRS regulations, you cannot change your elections until the next annual open enrollment period, unless you have a qualified life event during the year. You have a limited window of time to make your changes (30 days). Please contact your Benefits Specialist if you have a qualifying event.

The following are examples of the most common qualified life events:

- Marriage or divorce.
- Birth or adoption of a child.
- Dependent reaching the maximum age of 26.
- Death of a spouse or dependent.
- Change in child custody.
- Change in coverage election made by your spouse during his/ her employer's open enrollment period.
- The termination of employment (or the commencement of employment) of your spouse.

BENEFIT CONTACTS FOR QUESTIONS

	Phone Number	Website/Email
CAEI HUMAN RESOURCES CONTACTS	DeAnna Coulter, 563-484-4522 Jessica Bousselot, 563-484-4529	dcoulter@caeiowa.org jbousselot@caeiowa.org
GENERAL QUESTIONS-CAEI BENEFIT CONSULTANTS	Kelly Spies, 563-468-4051 Sara Bradshaw, 515-223-6940	kspies@holmesmurphy.com sbradshaw@holmesmurphy.com
HEALTH-WELLMARK	800-524-9242	www.wellmark.com
HEALTH REIMBURSEMENT-ADVANTAGE ADMINISTRATORS	800-383-1623	www.advantageadmin.com
DENTAL-METLIFE	800-275-4638	www.metlife.com
VISION-METLIFE	855-638-3931	www.metlife.com
LIFE & DISABILITY-METLIFE	866-492-6983	www.metlife.com
LIFESTYLE SPENDING ACCOUNT-WEX	866-451-3399	www.wexinc.com

HEALTH BENEFIT HIGHLIGHTS

Health Insurance

Your medical insurance plan is administered by **Wellmark BCBS of Iowa**.

	Plan 1 - HMO Blue Advantage Plan		Plan 2 - PPO Alliance Select Plan	
	IN-NETWORK	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
ANNUAL DEDUCTIBLE *(your cost before the plan pays)*				
INDIVIDUAL	$1,000 (CAEI Then Pays 80% up to $5,000)	N/A	$1,000 (CAEI Then Pays 80% up to $5,000)	$10,000
FAMILY	$2,000 (CAEI Then Pays 80% up to $10,000)	N/A	$2,000 (CAEI Then Pays 80% up to $10,000)	$20,000
OUT OF POCKET MAXIMUM *(the maximum you could pay per year)*				
INDIVIDUAL	$2,500 (Reduced from $6,500 by AA Benefit)	N/A	$2,500 (Reduced from $6,500 by AA Benefit)	$20,000
FAMILY	$5,000 (Reduced from $13,000 by AA Benefit)	N/A	$5,000 (Reduced from $13,000 by AA Benefit)	$40,000
COPAYS *(fixed provider fees)***/COINSURANCE** *(what you pay after the deductible)*				
COINSURANCE	20%	N/A	20%	50%
PREVENTIVE CARE	No Charge	N/A	No Charge	Deductible, 50%
PRIMARY CARE VISIT	$25 Copay	N/A	$25 Copay	Deductible, 50%
SPECIALIST VISIT	$100 Copay	N/A	$100 Copay	Deductible, 50%
VIRTUAL VISITS	$25 Copay (Doctors on Demand)		$25 Copay (Doctors on Demand)	
MENTAL HEALTH VISIT	$25 Copay	N/A	$25 Copay	Deductible, 50%
CHIROPRACTIC CARE	$25 Copay	N/A	$25 Copay	Deductible, 50%
URGENT CARE	$50 Copay	N/A	$50 Copay	Deductible, 50%
EMERGENCY SERVICES	$250 Copay then Deductible		$250 Copay then Deductible	
LAB SERVICES	Deductible, 20%	N/A	Deductible, 20%	Deductible, 50%
IMAGING (CT/MRI)	Deductible, 20%	N/A	Deductible, 20%	Deductible, 50%
INPATIENT FACILITY	Deductible, 20%	N/A	Deductible, 20%	Deductible, 50%
OUTPATIENT FACILITY	Deductible, 20%	N/A	Deductible, 20%	Deductible, 50%
Rx COVERAGE-BLUERx COMPLETE *(the amount you pay for medications)*				
GENERICS	$10 Copay		$10 Copay	
PREFERRED BRANDS	$40 Copay		$40 Copay	
NON-PREFERRED BRANDS	$85 Copay		$85 Copay	
SPECIALTY	Generic & Biosimilar Specialty: $50 Copay / Preferred Specialty: $100 / Non-Preferred Specialty: Deductible, 50%		Generic & Biosimilar Specialty: $50 Copay / Preferred Specialty: $100 / Non-Preferred Specialty: Deductible, 50%	

HOW TO FIND AN IN-NETWORK PROVIDER:

1. Go to www.wellmark.com. Click on Member Resources in the middle of the page and then "Find a Provider". From there, you will select Search Now. Then select "Choose a location and plan."
2. Enter your zip code. Then click on "Browse a list of plans". Select either Wellmark Blue HMO for Plan 1 or Wellmark Blue PPO for Plan 2. You can search by name, specialty or type.
3. If you need additional assistance, you may call Wellmark at the number listed on page 2.

MEDICAL PARTIAL EMPLOYER FUNDING EXPLAINED

You may have noticed there is an extra component to your health insurance! That is because your employer, CAEI, pays for part of your insurance expenses after you have hit your portion of the deductible. Here is how it works!

1. You Get Services

Your medical provider will file your claim with Wellmark using the information from your Wellmark ID Card.

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2. Wellmark Settles Your Claim

All claims are submitted to Wellmark first for settlement under your high deductible plan. Wellmark will make a payment if applicable to your provider of service and send you an explanation of benefits (EOB).

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3. Advantage Administrators Settles Your Claim

Advantage Administrators receives the EOB from Wellmark for processing on your low deductible plan. Advantage Administrators will make a payment if applicable to your provider of service.

Be sure to log on to the Advantage Administrators portal (www.advantageadmin.com) to view your claims information!

ADDITIONAL BENEFITS

Dental Insurance

Your dental insurance plan is through **Metlife**.

	Dental	
	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE		
INDIVIDUAL	$25	$25
FAMILY	$75	$75
MAXIMUMS		
INDIVIDUAL ANNUAL MAX	$1,250	
SERVICE CATEGORIES		
PREVENTIVE SERVICES	No Charge	No Charge
BASIC SERVICES	20% Coin.	20% Coin.
MAJOR SERVICES	Deductible + 50% Coin.	Deductible + 50% Coin.
ORTHODONTIA	50% (To Age 19 Only-$1,000 Lifetime Maximum)	

HOW TO FIND AN IN-NETWORK PROVIDER:
1. Go to www.metlife.com/dental. From there, go to the "Find a Dentist" section.
2. Enter in your zip code and your network is "PDP Plus."
3. If you need assistance, you may call Metlife at the number listed on page 2.

Vision Insurance

Your vision insurance plan is through **Metlife**.

	Vision	
	IN-NETWORK	OUT-OF-NETWORK
EXAMS & MATERIALS		
EXAMS	$20 Copay	Up to $45
MATERIALS	$20 Copay	See Below
FREQUENCY GUIDELINES		
EXAM/LENSES/FRAMES	12 Months/12 Months/24 Months	
BENEFITS		
FRAMES	Up to $130 then 20% Off	Up to $70
LENSES	Materials Copay	Up to $30-$100
CONTACTS	Up to $130 ($60 Fit May Apply)	Up to $105
NECESSARY CONTACTS	Materials Copay	Up to $210

HOW TO FIND AN IN-NETWORK PROVIDER:
1. Go to www.metlife.com/vision. From there, click on "Find Vision Provider."
2. Enter in your zip code and your network is "Metlife Vision PPO."
3. If you need assistance, you may call Metlife at the number listed on page 2.

Life/AD&D Insurance

Your life/AD&D insurance plan is through **Metlife**.

	CAEI Paid Life
BENEFITS	
BENEFICIARY AMOUNT	1x Your Annual Earnings up to $50,000
BENEFIT REDUCTION	Life benefits will reduce by 35% at the age of 70, 55% at the age of 75, and 70% at the age of 80.
CONVERSION	You have the option to take your life insurance with you if you leave CAEI. You may convert it to a whole life policy and build cash value.

Disability Insurance

Your disability insurance plan is through **Metlife**.

	CAEI Paid Disability
BENEFITS	
OVERVIEW	This coverage will help you replace a portion of your income during a disability.
ELIMINATION PERIOD	Benefits will begin after 90 days of disability.
BENEFIT	You will receive 60% of your monthly earnings, not to exceed $4,500 per month. Benefits will continue for as long as you're disabled or until social security normal retirement age.

Supplemental Life/AD&D Insurance

Your supplemental life/AD&D insurance plan is through **Metlife**.

	Supplemental Life/Accidental Death & Dismemberment		
BENEFITS			
	Employee	**Spouse***	**Child(ren)**
MULTIPLES OF	$10,000	$5,000	Choice of: $1,000/$2,000/$4,000/$5,000/$10,000
GUARANTEE ISSUE AMOUNT	**$100,000**	**$25,000**	**$10,000**
DEFINITION OF GUARANTEE ISSUE	Any purchase or increase in benefits over the guarantee issue amount above, which does not take place within 31 days of the employee's or dependent's initial eligibility, is subject to evidence of insurability (medical questionnaire). The coverage is then subject to the approval of Metlife.		
MAXIMUM ELECTION	The Lesser of 5x Your Basic Annual Earnings, or $500,000	$100,000	$10,000
AD&D COVERAGE	The AD&D amount is the same as the supplemental term life coverage amount.		

*Spouse rates are based on the employee's age.
You must elect coverage on yourself if you would like to elect coverage on your spouse and/or dependent child(ren).
Please see EASE for rates.

ADDITIONAL BENEFITS

Employee Assistance Program through Personal Assistant Services (PAS)
Each of us experience demands for our time and energy, both on and off the job. The key to balancing it all is having access to the right tools, resources, and support. Your EAP is like having your own personal concierge service. PAS provides you with a wealth of confidential, professional services that can help you address challenges and strengthen your work and home life.

Your EAP is **free, confidential and available 24/7 to you and your dependents**! Use this benefit for the following and MORE!
800-356-0845 / www.paseap.com

Counseling Services	Child Care Consultation	Elder Care Management	Financial & Legal Consultation	Health & Life Coaching
- Marital/relationship strengthening - Depression - Anxiety - Grief & Loss - Job stress - Anger - Addiction - Trauma	**PAS can help you find:** - Licensed day care - Part day program - Care for special needs children - Emergency and back up care - Summer camps	**Care coordination:** - Needs assessment - Assistance in nursing home, retirement community or residential placement - Support for long distance caregivers **Financial consultation:** - Medicaid/Medicare - Assistance with Medicare supplements	**Financial:** - Cash flow & budget planning - Debt reduction & credit management - Bankruptcy prevention - Insurance - Estate planning **Legal:** - Family law - Vehicle matters - Housing & real estate matters	**Health:** - Making lifestyle changes to improve health - Nutrition & exercise to improve wellness - How to communicate with doctors **Life:** - Identify & achieve goals - Consider options when making a significant decision - Sort through challenges

Lifestyle Spending Accounts through WEX
100% Paid For by CAEI
CAEI wants to ensure you're taking care of all aspects of your wellbeing! Anyone employed as of January 1, 2023 will be able to reimburse themselves for a wide variety of lifestyle expenses *(employees hired after January 1 will not be eligible for this benefit until 2024)*. Once you have received your welcome email, simply download the mobile app or create an online account to submit your lifestyle expenses for reimbursement.

Full-time employees: up to $400 per year
Part-time employees: up to $200 per year

Physical Wellness	Financial Wellness	Emotional Wellness
- Athletic equipment and accessories - Exercise equipment - Gym, health club, spa and fitness membership - Fitness classes - Lessons (golf, swimming, tennis, etc) - Personal trainer - Fitness trackers - Entry fees (marathons, leagues, etc) - Passes (ski, snowboard, golf, swimming, etc) - Nutritional supplements	- Rent & utility payments - Car repairs - Student loan reimbursement - Home purchase expense reimbursement (down payment, closing costs, etc) - Financial adviser & planning classes - Financial seminars and classes - Identity theft services	- Meditation classes - Non-medical counseling (marital, parental, etc) - Retreats (leadership, spiritual, etc) - Pet care (walkers, day care, grooming, etc) - Camping (equipment fees, etc) - Personal development classes (art, cooking, etc) - Annual park passes

LSA reimbursements are taxable income that will be reflected in your W2 earnings.

PER PAY PERIOD (18 ANNUALLY) BENEFIT COSTS

Benefit	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Medical Plan 1 - HMO	$88.00	$394.00	$366.00	$592.00
Medical Plan 2 - PPO	$160.00	$560.00	$513.33	$800.00
Dental Plan	$23.39	$46.76	$53.75	$78.30
Vision Plan	$4.79	$9.61	$8.14	$13.43
Life Plan	100% Paid for By CAEI			
Disability Plan	100% Paid for By CAEI			
Supplemental Life Plan	Please See EASE for Rates (Rates Based on Age and Coverage Amount Elected)			

IMPORTANT NOTICES

IMPORTANT NOTICE FROM CAEI ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE FOR YOUR MEDICAL PLAN
Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with CAEI 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. CAEI has determined that the prescription drug coverage offered by CAEI's 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 CAEI coverage may be affected. If you do decide to join a Medicare drug plan and drop your current CAEI coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with CAEI 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 November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information. 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 CAEI 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:	1/1/2023
Name of Entity/Sender:	CAEI
Contact:	Human Resources
Address:	500 E 59th St Davenport, IA 52807
Phone Number:	563-324-3236

HIPAA SPECIAL ENROLLMENT NOTICE
This notice is being provided to insure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage (including Medicaid and State Child Health Coverage)
If you are declining coverage for yourself or your dependents (including spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within *30 days* after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage. Some plans may allow longer than 30 days, so please refer to your plan documents for your specific plan details.

Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this health plan.

Marriage, Birth or Adoption
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, or placement for adoption. Some plans may allow longer than 30 days, so please refer to your plan documents for your specific plan details.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or State Child Health Coverage
If you or your dependents lose eligibility for coverage under Medicaid or State Child Health Coverage Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP or the determination of eligibility for a premium assistance subsidy. Example: When you are hired, your children received health coverage under CHIP and you did not enroll them in this health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

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

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

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

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

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

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.
- Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:
- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

IMPORTANT NOTICES

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

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

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

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

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

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

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

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

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

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

Plan contact information
CAEI
500 E 59th St, Davenport IA 52807
563-324-3236

WOMEN'S HEALTH & CANCER RIGHTS ACT OF 1998
In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications at all stages of the mastectomy, including lymph edemas.

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under this plan.

EXPANDED COVERAGE FOR WOMEN'S PREVENTIVE
Under the ACA, CAEI provides female participants with expanded access to recommended in-network preventive services, without cost sharing. Additional women's preventive services include: well-women visits, gestational diabetes screen, HPV DNA testing. STI counseling and HIV screening and counseling, contraception and contraception counseling, breastfeeding support, supplies and counseling and domestic violence screenings. Please see your Benefits Specialist for benefit details.

60-DAY SPECIAL ENROLLMENT PERIOD
In addition to the qualifying events listed in this document, you and your dependents will have a special 60-day period to elect or discontinue coverage if:

- You or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- You or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT
Under federal law, health insurance issuers generally may not 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 delivery by cesarean section. However, the policy/plan may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, the policy/plan may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hours (or 96 hours) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a policy/plan may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain provider or facilities, or to reduce your out-of pocket costs, you may be required to obtain precertification.

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE
PART A: General Information
Since key parts of the health care law took effect in 2014, there is another way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Typically, you can enroll in a Marketplace health plan during the Marketplace's annual Open Enrollment period or if you experience a qualifying life event.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.12% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution — as well as your employee contribution to employer-offered coverage — is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How can I get more information?
For more information about your coverage offered by your employer, please check your summary plan description or contact your Human Resources Dept at (563) 324-3236.

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.

Notes