



Employee Benefits Program

BENTON COUNTY
All Eligible Employees

July 1, 2026 – June 30, 2027



Welcome to your Employee Benefits!

Benton County is pleased to offer a wide range of health and welfare benefits to its employees and their families. These company-sponsored benefits are an important part of your total compensation package. They represent a valuable asset to our employees and their families and demonstrate an investment by Benton County in our employees. We are proud of our comprehensive benefits program and are committed to continuously improving the plans that make up our offerings.

This guide was created to answer some of the questions you may have about your benefits. Please read it carefully along with any supplemental materials you receive.

If you have any benefits related questions or concerns, please do not hesitate to call Benton County's Benefits Department.



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PLEASE NOTE: This booklet provides a summary of the benefits available, but it is not your Summary Plan Description (SPD). Benton County reserves the right to modify, amend, suspend, or terminate any plan at any time, and for any reason without prior notification. The plans described in this book are governed by insurance contracts and plan documents, which are available for examination upon request. We have attempted to make the explanations of the plans in this booklet as accurate as possible. However, should there be a discrepancy between this booklet and the provisions of the insurance contracts or plan documents, the provisions of the insurance contracts or plan documents will govern. In addition, you should not rely on any oral descriptions of these plans, since the written descriptions in the insurance contracts or plan documents will always govern.

Important Contact Information

Policy	Group #	Web / Email	Phone
Medical and Prescription Wellmark BCBS	76802	mywellmark.com	800-524-9242
Partial Self-Fund Auxiant	1966	auxiant.com	800-475-2232
Flexible Spending Accounts Health Equity / Wageworks		wageworks.com	877-924-3967
Dental Delta Dental	33544-6	deltadentalia.com	800-544-0718
Vision Delta Dental - EyeMed	1010686	eyemed.com	888-899-3747
Accident; Critical Illness Voya	739367	presents.voya.com/EBRC/ISAC	877-236-7564
Basic Life/AD&D; Voluntary Life/AD&D Insurance Madison National	29375	madisonlife.com	800-327-3660
Employee Assistance Program AllOne Health	JBF74	allonehealth.com/portal	800-437-0911
Benefits Consultant Gallagher		service.ryan@assuredpartners.com	515-493-0802



Questions, Problems or Concerns

Our goal is to make certain that you receive the correct coverage under the benefits plan. We are here to help with any issues that may arise. If you require assistance, have your ID number or Social Security Number available and follow these steps:

- **For claims assistance** call the applicable insurance carrier. Have your ID number, date of service, and provider name available.
- **Do you need an ID card?** If you do not have an ID card, please contact the insurance carrier to order your ID card or go online to the carrier's site to download an ID card.
- **If you require further assistance,** contact Benton County's Benefits representative.

Eligibility

Full-time employees with a schedule of **30 hours or more per week** are eligible for the benefits described in this guide, unless otherwise stated.

When Benefits Become Effective

Benefits are effective the first day of the month following 30 days of employment. Part-time, seasonal, temporary, internship, and contracted employees are not eligible to participate.

Eligible Dependents

Your dependents are eligible to participate in Benton County's benefit plans. Review the chart below for dependent eligibility criteria.

Coverage for eligible dependents generally begins on the same day your coverage is effective. Completed enrollment serves as a request for coverage and authorizes any payroll deductions necessary to pay for that coverage.

Pre-Tax Benefits: Section 125

Benton County's benefit plans utilize Section 125. This enables you to elect to pay premiums for health, dental, vision and flexible spending account coverage on a pre-tax basis. When you use pretax dollars, you will reduce your taxable income and have fewer taxes taken out of your paycheck. Under Section 125, you can have more spendable income than if the same deductions were taken on an after-tax basis.

Pre-tax Note: When you pay for your dependent's benefits on a pre-tax basis you are certifying that the dependent meets the IRS' definition of a dependent. [IRC §§ 152, 21 (b)(1) and 105(b)]. Children/spouses that do not satisfy the IRS' definition will result in a tax liability to you, such as changing that dependent's election to a post-tax election or receiving imputed income on your W-2 for the dependent's coverage that should not have been taken on a pre-tax basis.

ELIGIBILITY	Spouse	Child(ren)
Medical	Legal Spouse	Up to age 26; or unmarried, full-time student
Dental	Legal Spouse	Up to age 26; or unmarried, full-time student
Vision	Legal Spouse	Up to age 26; or unmarried, full-time student
Accident / Critical Illness	Legal Spouse	Up to age 26
Voluntary Life	Legal Spouse	Up to age 26
Employee Assistance Program	Legal Spouse	Up to age 26

**Dependent coverage varies by benefit. Refer to carrier certificates for details.*

How to Enroll – Employee Navigator

OPEN ENROLLMENT PERIOD

Benton County's annual enrollment period will be held **May 1 – May 15, 2026**. Be sure to go online during the assigned time, or within 30 days of becoming eligible, to review your current benefits and make any changes for the upcoming plan year.



Have social security numbers and birth dates for all dependents and beneficiaries available prior to enrolling.



TIP: If you miss a step, you will see **ENROLLMENT NOT COMPLETE** in the progress bar. Click on any incomplete steps to finish.

NEWLY HIRED/ELIGIBLE EMPLOYEES

New hires and newly eligible employees **MUST** complete online enrollment even if choosing to waive coverage. Benefits, if elected, will begin **on the first date of eligibility**.

Enrolling In Your Benefits

Please review this guide to gain a full understanding of the plans offered. Once the open enrollment window opens, please visit:

<https://gbpenroll.employeenavigator.com>

- To Register as a new user, enter your Name, Last 4 Digits of SSN, Birthdate, and your Company Identifier (see below)
- Create your unique username and password

COMPANY IDENTIFIER: BentonCounty

- Begin the enrollment process by clicking the **Start Enrollment** button in the main welcome section.
- Update any necessary changes and click the **Save & Continue** button.
- Next, add all dependents (spouse and children) that you will be covering on any of the benefit plans. Do this by clicking the **add dependent +** link at the top of the screen, once for each dependent. Proceed by clicking the **Save & Continue** button.
- You are now ready to begin enrolling or waiving your benefits through the guided enrollment process. On each screen you will select who you are enrolling at the top, and which benefits you want below, or waive by clicking the **Don't want the benefit?** button. If you are enrolling, you will move from plan to plan by clicking the **Save & Continue** button.
- To enroll dependents in a benefit, click the checkbox next to the dependent's name under **Who am I enrolling?**
- You will finish by reviewing the benefits you selected on the enrollment summary page to make sure they are correct. Click **Sign & Agree** to complete your enrollment. You can either print a summary of your elections or login throughout the year to view your summary online.

You can make changes to your selections prior to the enrollment deadline by logging back into the system and clicking on "Change My Elections."

Benefit Changes



The benefit elections you make during open enrollment or as a new hire will remain in effect for the entire plan year. You will not be able to change or revoke your elections once they have been made unless a life event status change occurs.

For purposes of health, dental, vision and flexible spending accounts, you will be deemed to have a life event status change if:

- *your marital status changes through marriage, the death of your spouse, divorce, legal separation, or annulment;*
- *your number of dependents changes through birth, adoption, placement for adoption, or death of a dependent;*
- *you, your spouse or dependents terminate or begin employment;*
- *your dependent is no longer eligible due to attainment of age;*
- *you, your spouse or dependents experience an increase or reduction in hours of employment (including a switch between part-time and full-time employment; strike or lock-out; commencement of or return from an unpaid leave of absence);*
- *gain or loss of eligibility under a plan offered by your employer or your spouse's employer;*
- *a change in residence for you, your spouse or your dependent resulting in a gain or loss of eligibility.*

To be permitted to make a change of election relating to your health, dental or vision coverage due to a life event status change, the change must result in you, your spouse or dependent gaining or losing eligibility for health, dental or vision coverage under this Plan or a plan sponsored by another employer by whom you, your spouse or dependent are employed. The election change must correspond with that gain or loss of eligibility.

You may also be permitted to change your elections for health coverage under the following circumstances:

- *a court order requires that your child receive accident or health coverage under this plan or a former spouse's plan;*
- *you, your spouse or dependent become entitled to Medicare or Medicaid;*
- *you have a Special Enrollment Right;*
- *there is a significant change in the cost or coverage for you or your spouse attributable to your spouse's employment.*

For purposes of all other benefits under the plan, you will be deemed to have a life event status change if the change is on account of and consistent with a change in status, as determined by the plan administrator, in its discretion, under applicable law and the plan provisions.

You must notify your Benefits Department within 30 days of a qualifying life event. Specific documentation will be required based on the qualifying life event.



Benefit Changes continued...

Event	Action Required	Results If Action Not Taken
New Hire:	Make elections within 30 days of hire date.	You and your dependents are not eligible until the next annual Open Enrollment period.
Marriage:	If electing coverage, your new spouse must be added to your elections within 30 days of the marriage date. A copy of the marriage certificate must be presented.	Your spouse is not eligible until the next annual Open Enrollment period.
Divorce:	The former spouse must be removed within 30 days of the divorce. A copy of the divorce decree must be presented.	Benefits are not available for the divorced spouse and will be recouped if paid erroneously.
Birth or adoption of a child:	The new dependent must be enrolled in your elections within 30 days of the birth or adoption, even if you already have family coverage. A copy of the birth certificate, footprints, or hospital discharge papers must be presented. Once you receive the child's Social Security Number, be sure to contact HR to update your child's insurance information record.	The new dependent will not be covered on your health insurance until the next annual Open Enrollment period.
Death of a spouse or dependent:	Remove the dependent from your elections within 30 days from the date of death. Death certificate must be presented.	You could pay a higher premium than required and you may be overpaying for coverage.
Your spouse gains or loses employment that provides health benefits:	Add or drop health benefits from your elections within 30 days of the event date. A letter from the employer or insurance company must be presented.	You need to wait until the next annual Open Enrollment period to make any change.
Loss of coverage with a spouse:	Change your elections within 30 days from the loss of coverage. A letter from the employer must be provided.	You will be unable to enroll in the benefits until the next annual Open Enrollment period.
Changing from full-time to part-time employment (without benefits) or from part-time to full-time (with benefits):	Change your elections within 30 days from the employment status change in order to receive COBRA information or to enroll in benefits as a full-time employee. Documentation from the employer must be provided.	Benefits may not be available to you or your dependents if you wait to enroll in COBRA. Full-time employees will have to wait until the annual Open Enrollment period.



Medical Coverage - Wellmark

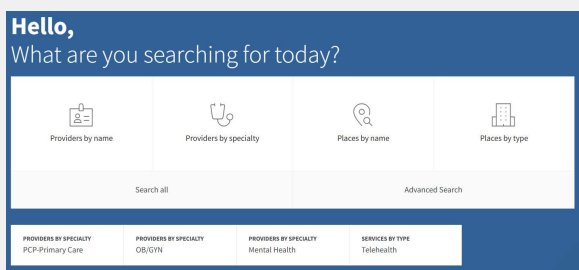
Benton County is proud to offer you a medical plan through Wellmark Blue Cross Blue Shield. Coverage under the plan includes comprehensive medical care and prescription drug coverage. The plan also offers many resources and tools to help you maintain a healthy lifestyle. Below is a brief description of the network and features.

BLUE POS

Wellmark Blue Cross Blue Shield **BLUE POS** is a Point-of-Service plan utilizing Wellmark's Iowa-based network. Members can access the full Iowa network, including 100% of hospitals and 98% of physicians across the state. Members must designate a Primary Care Provider, however, there is no referral needed to see a specialist. Members do have out-of-network benefits, although a greater member cost-share applies. (Emergency medical conditions treated as in-network)

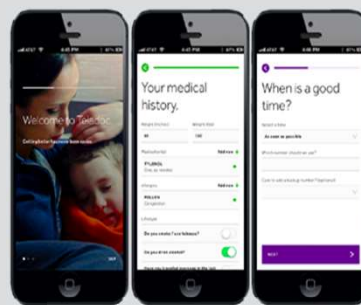
Find an In-Network Provider

You can search for in-network providers or facilities using your Wellmark ID and zip code. Or, log in to myWellmark.com to more easily search.



DOCTOR ON DEMAND

We have partnered with Doctor on Demand to provide you with 24/7 access to virtual care. Doctor on Demand can diagnose, treat, and prescribe medication, when necessary, for a variety of issues. It is convenient access to quality healthcare, when and where you need it.



We encourage you to download the Wellmark Mobile App and use it for locating providers, monitoring the status of claims, and for viewing your Member ID Card. The app is free and available for iOS and Android.

GLOSSARY OF TERMS

Deductible: The amount you pay for healthcare services before your health insurance begins to pay.

Out-of-Pocket Maximum: This amount is the most you will pay for covered services in a plan year. After you spend this amount on copays, deductibles, and coinsurance, then your health plan pays 100 percent of costs for covered benefits.

In-Network: A group of doctors, clinics, hospitals, and other healthcare providers that have an agreement with your medical plan provider. You will pay less when you utilize in-network providers.

Out-of-Network: Care received from a doctor, hospital, or other provider that is not part of the medical plan agreement. The cost will be greater when you use an out-of-network provider.

Coinsurance: Your share of the costs of a healthcare service, usually figured as a percentage. Coinsurance applies after you have paid your plan's deductible. Your plan pays a certain percentage of services, and you pay the remaining the balance.

Copay: A fixed amount you pay for a specific service at the time you receive care.

Premium: The amount that is taken out of your paycheck for the plan coverage you have elected.

How Our Medical Plan Works

**Let's
get
started!**

Get Your Preventive Care



**PLAN
PAYS
100%**

Here are some key things covered under preventive care:

- Adult physicals
- Mammograms
- Well-child exams and immunizations
- Prostate and colorectal screenings
- Routine prenatal maternity services
- Pap tests

Age and gender appropriate visit / screenings

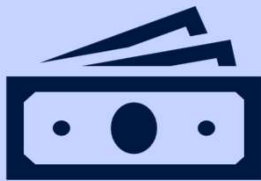
Office Visits

When seeing an in-network provider, you will pay coinsurance at the time of your appointment. Medical coinsurance counts toward your medical out-of-pocket maximum.

Prescription Medications

You will pay a copay at the point-of-sale for covered prescription medications. Prescription copays count toward your medical out-of-pocket maximum.

For Most Other Care (including Out-of-Network Office Visits): Meet Your Deductible



YOU PAY 100% of the total allowed amount until you meet your **DEDUCTIBLE**. Once you meet your deductible, you will pay a coinsurance percentage until you reach your out-of-pocket maximum.

Pay Your Share

After you meet your deductible, you'll pay a COINSURANCE for most covered services.



IN-NETWORK
YOU PAY 20%
PLAN PAYS 80%

Reach the Out-of-Pocket Max

After you reach the OUT-OF-POCKET MAX, the plan will pay 100% of covered expenses for the remainder of the year.



PLAN PAYS 100%

**Plan
year
ends**

How Our Partial Self-Fund Plan Works

We are very pleased with the benefits plan and pricing that we are able to offer you for the upcoming plan year. Costs are kept low because Benton County uses a partially self-funded (PSF) plan from your health insurance carrier.

What does that mean?

It means that your employer pays for a higher deductible plan from your insurance carrier (“Core Plan”) but offers you a lower deductible plan (“PSF Plan”). This new plan is lower in cost to you than other plans available through the insurance carrier. To utilize a partially self-funded plan, we have contracted with a Third-Party Administrator (TPA).

When you visit a healthcare provider, your claims will be filed with your insurance carrier. Your insurance carrier will process your claim under the “Core Plan” and send you an Explanation of Benefits (EOB) reflecting the higher deductible plan. **This is not a bill and does not reflect your “PSF” deductible.**

Your insurance carrier sends the same EOB to the TPA, who will review this and process payments to your health care provider based on your “PSF Plan” deductible. The TPA sends you an adjusted EOB that reflects your true deductible.

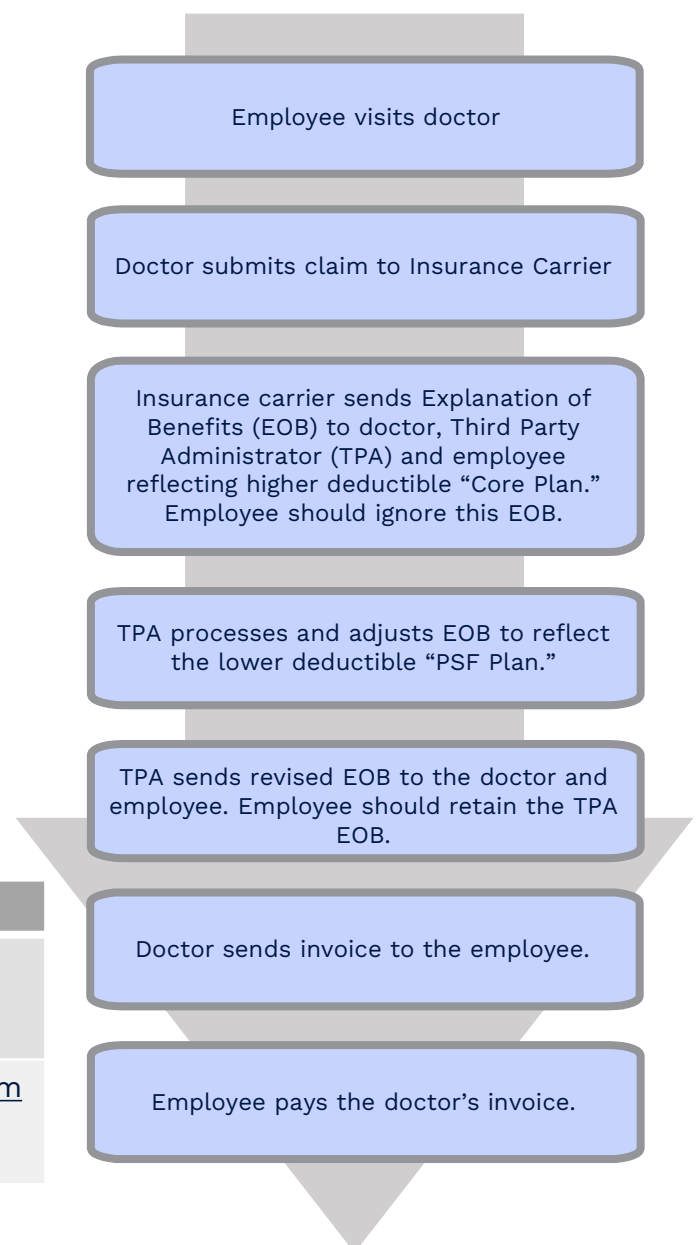
Employees are responsible for any deductibles, copays, or coinsurance on the “PSF Plan.” Benton County is responsible for amounts over the “PSF Plan” deductible.

Do not make a payment to your provider based on any EOB. These are not bills, they are simply explanations.

You will receive a bill from your healthcare provider based upon the adjusted EOB from your TPA.

CORE PLAN	PSF PLAN
<u>Deductible</u> \$5,000 (ind.) \$10,000 (fam.)	<u>Deductible</u> \$500 (ind.) \$1,000 (fam.)
<u>Out-of-Pocket Maximum</u> \$7,500 (ind.) \$15,000 (fam.)	<u>Out-of-Pocket Maximum</u> \$1,000 (ind.) \$2,000 (fam.)

Any claim with a “member responsibility” amount follows the PSF process below



Medical Plan

Medical Coverage		BLUE POS \$500 PSF PLAN In-Network, You Pay	BLUE POS \$500 PSF PLAN Out-of-Network, You Pay
Deductible (Ind./Fam.)		\$500 / \$1,000	\$500 / \$1,000
Deductible Type		Embedded	Embedded
Out-of-Pocket Max. (Ind./Fam.)		\$1,000 / \$2,000	\$1,000 / \$2,000
Coinsurance		20%	40%
Preventive Care		No charge for recommended preventive services	Deductible + Coinsurance
Office Visits	Primary Care	20% Coinsurance; Deductible waived	Deductible + Coinsurance
	Specialist	20% Coinsurance; Deductible waived	Deductible + Coinsurance
	Chiropractor	20% Coinsurance; Deductible waived	Deductible + Coinsurance
	Mental Health	20% Coinsurance; Deductible waived	Deductible + Coinsurance
	Virtual Visits	\$0 (w/ Doctor on Demand)	Deductible + Coinsurance
Urgent Care		20% Coinsurance; Deductible waived	Deductible + Coinsurance
Emergency Room		Deductible + Coinsurance	Same as In-Network
Imaging Services		Deductible + Coinsurance	Deductible + Coinsurance
Inpatient Hospital		Deductible + Coinsurance	Deductible + Coinsurance
Outpatient Hospital		Deductible + Coinsurance	Deductible + Coinsurance

Prescription Coverage		BLUE POS \$500 PSF PLAN In-Network, You Pay	BLUE POS \$500 PSF PLAN Out-of-Network, You Pay
Deductible (Ind./Fam.)		\$50 / \$100	\$50 / \$100
Out-of-Pocket Max. (Ind./Fam.)		Same as Medical	Same as Medical
Prescription Copays			
Tier 1		\$10	\$10
Tier 2		\$30	\$30
Tier 3		\$60	\$60
Specialty			
Generic		\$60	Not Covered
Preferred		\$150	
Non-Preferred		\$300	

Prescription Coverage

Your prescription drug benefit is part of your Medical plan and is based on a tiered drug system. Cost is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned a tier. Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on to **myWellmark.com**.

The name of your prescription drug benefit Prescription Drug List is: **Blue Rx Value Plus**.



Rx Mail Order Program

Save time and money by filling maintenance drugs through the mail order program. The Mail Order Program benefits members who are on long-term medications for chronic conditions such as diabetes, high cholesterol, high blood pressure, depression or asthma. By utilizing the Mail Order Program, you can receive a 90-day supply of medication for the equivalent of two retail copayments. That's a savings of one copayment for every 90-day supply.

To set up mail service, log in to myWellmark.com, select Find a Pharmacy and register for Caremark.com. Or let CVS Caremark walk you through registration by calling 866-611-5961.

Medicare Part D

The prescription drug benefit is creditable coverage. Medicare-eligible participants need not enroll in a separate Medicare D drug plan. The **Notice of Creditable Coverage** is located on **p. 6** of your **Notice & Disclosure** packet.

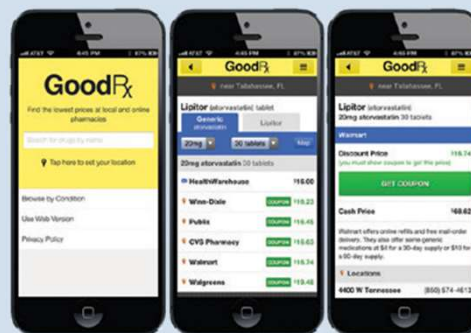
Save Money with Generics

Generic drugs are made with the same active ingredients and produce the same effects in the body as their brand-name equivalents. That's because they're held to the same federal standards for safety and performance as the brand names. Because they are not branded, generics can sell for 30 percent to 80 percent less than their brand-name equivalents.

GoodRx Mobile App

We encourage you to download and use the GoodRx Mobile App to help you save on your prescription drug costs. Prices for prescription drugs vary widely between pharmacies. The cost of a prescription may differ by more than \$100 between two pharmacies across the street from each other.

GoodRx doesn't sell the medications, they will tell you where you can get the best deal on them. GoodRx will show you prices, coupons, discounts, and savings tips for your prescription at pharmacies near you.



Flexible Spending Accounts



Flexible Spending Accounts (FSAs) are another way to save money tax-free for health care and dependent care expenses. You will fund the account through payroll deductions. The funds may be used by you or your dependents, even if you are not covered by your employer-sponsored medical plan. The money that you contribute to your FSA is not subject to social security tax, federal tax, or, in most cases, state income tax.



**The FSA Plan Year is January 1 - December 31.
FSA Open Enrollment is held annually in December.**

Account	HSA Participants	Non-HSA Participants	How it works
Healthcare FSA	X	✓	Employee-funded. You can use funds for all unreimbursed healthcare related expenses. Federal regulations do not allow you or your spouse to participate in an HSA and an FSA.
Dependent Care FSA	✓	✓	Employee-funded. You can use funds for all dependent care-related expenses such as daycare, nursery school, or elder care.

2026 HCFSAs
Annual
Contribution
Limit:

\$3,400

Health Care Flexible Spending Account (HCFSAs)

Federal regulations do not allow participation in an HSA and this type of account.

Eligible health care expenses include many of the out-of-pocket expenses you pay to maintain your health and well-being. These include deductibles and coinsurance expenses not covered by your medical plan, expenses for glasses or contact lenses, and more.

DCFSAs Annual
Contribution
Limit:

\$7,500

Or \$3,750 if you are
married and file a
separate tax return.

Dependent Care Flexible Spending Account (DCFSAs)

You may use pre-tax dollars from your DCAP to pay expenses for care when the services enable you and your spouse to work outside of the home. Expenses include the care for a dependent child, spouse, or elderly parents. Only the portion of expenses that enable you to remain employed are eligible. Educational expenses are not eligible.

“Use it or lose it” FSA Rollover Provision - HCFSAs only

Benton County has elected to participate in the FSA rollover provision, allowing employees to rollover up to \$660 from one plan year to the next. You must be enrolled in an HCFSAs both plan years. You are still encouraged to consider your expenses carefully before you decide how much to contribute to each Flexible Spending Account. As a reminder, your election will cover the period from January 1 through December 31. You should not contribute more than you are reasonably certain to use.



Dental Coverage

Delta Dental PPO Plus Premier

The Dental Insurance Plan offers you flexibility to see the provider of your choice each time you seek dental care. The plan covers a scheduled portion of your dental expenses based on the procedures being performed. Coverage is available regardless of which dentist you visit, however, out of pocket costs will be less when visiting an In-Network provider. To locate a list of network providers, visit the carrier's website (details provided on Contacts page). Your dental plan features a dual network – Delta Dental PPO Plus Premier. Both provider panels provide network discounts, but PPO providers provide services with the greatest member savings.

Dental Coverage	Delta Dental PPO	Delta Dental Premier / Non-Participating*
Annual Benefit Maximum	\$2,000	\$2,000
Deductible (Ind./Fam.)*	\$15 / \$45	\$25 / \$75
Preventive Coinsurance	0%	0%
Basic Coinsurance	10%	20%
Major Coinsurance	20%	20%
Ortho Lifetime Maximum	\$2,000	\$2,000
Ortho Coinsurance	50%	50%

*Deductible waived for Preventive Services

This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.

Out-of-Network Providers & Balance Billing

*Under the Delta Dental Premier Network, the plan pays the same amount to out-of-network providers (“non-participating”) as it would for in-network providers. Please note, though, that providers that do not participate can “balance bill” you for any difference between their charge and what the plan pays. Therefore, using non-participating providers may result in significant patient liability.



CheckUp Plus

CheckUp Plus encourages you to use preventive services while allowing you to get the most out of your annual benefit maximum. With this plan enhancement, **diagnostic and preventive dental services do not count toward your annual benefit maximum.** This promotes regular visits to the dentist and allows you to save on costs.

Vision Coverage

Dental Vision / EyeMed

Your vision benefits are highlighted below. For a list of network providers in your area, you can call or visit the carrier's website (details provided on Contacts page). The vision benefits are structured to reimburse a scheduled amount for covered vision care expenses, with reimbursement being greater if you visit an in-network provider. The general details of your plan are provided in the chart below. Additional vision plan details can be found by logging into your online account.



Vision Coverage	Description	Frequency	Cost
Eye Exam	Focuses on eye health and vision	Once every 12 months	\$10 COPAY
Frames	\$130 allowance	Once every 24 months	Remaining balance
Lenses	Single vision, bifocal, trifocal, and lenticular lenses	Once every 12 months	\$10 COPAY
Lens Options	Standard progressive lenses	Once every 12 months	\$75 COPAY
	Premium progressive lenses		\$95 and up
Other Lens Options	Standard polycarbonate	Once every 12 months	\$40 COPAY
	UV treatment		\$15 COPAY
	Plastic scratch coating		\$15 COPAY
	Solid or gradient tint		\$15 COPAY
	Standard anti-reflective coating		\$45 COPAY
	Photochromatic / Transitions		\$75 COPAY
Contacts (in lieu of glasses)	\$130 allowance	Once every 12 months	Remaining balance
Extra Savings	Refractive Laser Surgery: See Benefit Summary for discount information		

This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.

Out-of-Network Provider Coverage: Get the most out of your benefits and greater savings with an in-network provider. See official Plan Documents for out-of-network plan details.

Group Life Insurance

Employee Group Life Insurance



Plan Cost: 100% Employer Paid

Life insurance provides financial protection for your family in the event of your death. Benton County offers life insurance with an issue amount of **\$25,000** to all eligible employees. The cost of this benefit is paid by Benton County.

Your benefit amount will reduce to 65% at age 65. See Plan Document for additional reduction information.



Voluntary Group Life and AD&D Insurance



Plan Cost: 100% Employee Paid

Employee Voluntary Life

- Increments of \$10,000
- Guarantee Issue: \$80,000 if under age 60; \$10,000 if age 60-69; \$0 if age 70 or over
- Maximum Benefit: \$300,000; not to exceed 5x annual salary

Spouse Voluntary Life

- Increments of \$5,000
 - Guarantee Issue: \$25,000 if under age 60; \$5,000 if age 60 -69
 - Maximum Benefit: \$100,000 max; not to exceed 50% of employee benefit
 - Employee coverage required for spouse coverage
- Age Reductions begin at age 65 (Employee and Spouse)

Dependent Child Voluntary Life

- Option 1: age 14 days – 6 months = \$500; age 6 months – limiting age = \$5,000
- Option 2: age 14 days – 6 months = \$1,000; age 6 months – limiting age = \$10,000

Portability Options for Voluntary Life

If your coverage under the Policy ends prior to Social Security Normal Retirement Age, Life Insurance Benefits may be continued up to the Maximum Benefit shown in the Schedule of Benefits for this option.

You must apply to the Insurance Company and pay the required premium. If you continue coverage, coverage for your Spouse or Dependent Child may also be continued by you. Your Spouse or Dependent Child must be covered under the Policy on the date coverage would otherwise end. The application must be submitted within 31 days of your termination of employment or membership in an eligible class under the Policy.

Please see the insurance contract for full details and any exclusions.

If you wish to enroll in the Voluntary Life coverage, you will need to your enrollment within 30 days of your eligibility date, or any future enrollment will be subject to medical underwriting.

Accident Insurance

Accident insurance is a supplemental plan that covers costs related to an accident or injury, including non-medical expenses.

Who is it for?

Nobody can predict when an accident might happen. That's why accident insurance is an important add-on policy for people who want to supplement the health and disability insurance coverage they already have individually or through an employer.

What does it cover?

Accident insurance pays you a lump sum benefit after an accident happens. This could be a severe burn, broken bone or emergency room visit. Our accident insurance policies also offer coverage for spouses and dependent children.

Why should I consider it?

Accident insurance can be an affordable way to help supplement and cover additional expenses your health and disability insurance may not cover including expenses such as co-pays, deductibles, x-rays, ambulance services, deductibles, and even rent or groceries.

Accident insurance is portable, and payments are made directly to you.

You will receive these benefits if you meet the conditions listed in the policy.

ISAC pays for an employee-only CORE benefit for all employees enrolled in ISAC Group Medical Insurance.

ACCIDENT INSURANCE	CORE PLAN Benefit Amount	ENHANCED PLAN Benefit Amount
Initial Doctor Visit*	Physician: \$100 UC / ER: \$225	Physician: \$150 UC / ER: \$300
Major Diagnostic Exam	\$200	\$300
Dislocations	Up to \$6,400	Up to \$8,000
Fractures	Up to \$6,400	Up to \$10,000
Office Follow-up	\$100 per (max 6)	\$150 per (max 6)
Physical Therapy	\$75 per (max 6)	\$100 per (max 6)
Chiropractic*	\$50 per (max 6)	\$75 per (max 6)

*Doctor is a person licensed to practice medicine in the state.

**Follow-up care only. Chiropractor is not considered a doctor for purposes of initial visit benefit.

This is a short sample of included benefits. For full schedule of benefits, please see your benefit summary.



ACCIDENT COSTS EXAMPLE

Amanda falls off her bike and breaks her leg, which requires emergency treatment.

Average non-surgical broken leg treatment expense: **\$2,500**

Average major medical deductible: **\$1,500**

Major medical covers 80% of the surgical cost after the deductible is met, but Amanda's still responsible for 20%: **\$200**

Total out-of-pocket amount for Amanda (deductible + coinsurance): **\$1,700**

Amanda's accident policy pays:

- Initial treatment \$225
- Broken leg \$3,600
- Follow-up treatment \$100
- Physical therapy \$450

Total benefit payment **\$4,375**

This example is for illustrative purposes only. Your plan's coverage may vary. For specific amounts and details please see your benefit summary.



Wellness – All enrolled employees, spouses, and dependents are eligible to receive a \$100 wellness benefit.

24-Hour Coverage – Members have protection for on- and off-the-job injuries.

Sport Benefit – Accidents that occur while participating in an organized sporting activity are eligible for increased benefits.

Critical Illness Insurance

Critical illness is a supplemental benefit that pays a lump sum when a covered person is diagnosed with a severe illness.

Who is it for?

Critical illness insurance is a supplemental policy for people with health insurance. It provides additional payment to cover expenses like deductibles, treatments, and living costs.

What does it cover?

Critical illnesses include strokes, heart attacks, Parkinson's Disease, and cancer. Our policies can cover signature illness, helping you stay financially stable by paying you a lump sum if you're diagnosed with a covered illness.

Why should I consider it?

Health coverage may become more expensive, with higher co-pays, premiums, and deductibles. Critical illness insurance is an affordable way to help supplement and pay for additional expenses your health insurance doesn't cover.

Critical illness insurance is portable, and payments are made directly to you.

You will receive these benefits if you meet the conditions listed in the policy.

ISAC pays for an employee-only benefit of \$5,000 for all employees enrolled in ISAC Group Medical Insurance.



CRITICAL ILLNESS COSTS EXAMPLE

John is hospitalized after a heart attack and must cover the cost of the hospital stay.

Average heart attack hospitalization expense: **\$53,000**

Average Major Medical deductible: **\$1,500**

Major Medical covers 80% of the cost after the deductible is met, but John's still responsible for 20% until he meets his out-of-pocket maximum: **\$3,500**

Total out-of-pocket amount for John (deductible + coinsurance): **\$5,000**

John has a **\$10,000** Critical Illness policy which covers all out-of-pocket expenses plus additional money for miscellaneous expenses.

This example is for illustrative purposes only. Your plan's coverage may vary. For specific amounts and details, please see your benefit summary.

In addition, employees can enroll in a Voluntary Critical Illness policy:

The following coverages are available:

- **Employee: \$10,000, \$20,000 or \$30,000**
- **Spouse: \$10,000, \$20,000 or \$30,000**
(Spouse coverage not to exceed 100% of the employee's benefit.)
- **Child(ren): 50% of the employee's benefit**

**Plan Cost: 100% Employee Paid
Monthly Premiums Based on Age**

Employee Assistance Program

The Employee Assistance Program (EAP) through **AllOne Health** provides confidential assistance for life issues. This benefit is available at no cost to employees.

When should you contact the EAP?

Whenever you are experiencing one of life's challenges. They are available 24/7/365. The information you discuss through the EAP is kept confidential in accordance with federal and state laws.



Telephone Assistance:
800-451-1834



Online:
allonehealth.com/portal
Access Code: **JBF74**

***The EAP is for use by the employee, spouse, and any dependent child under age 26 and living at home.**

EAP FEATURES

MENTAL HEALTH

AllOne Health offers free consults and short-term care (6 sessions per issue, per year) through an extensive network of licensed counselors, and assistance with referrals for long-term care. They can help with:

- Stress
- Anxiety
- Depression
- Grief
- Child / teen development
- Family transitions
- Relationship conflicts
- Work concerns
- Alcohol and substance use
- Trauma
- Domestic abuse
- Burnout

EMOTIONAL WELL-BEING & BEHAVIORAL CHANGE

AllOne Health can also help you proactively support your emotional wellbeing and mental health through services that encourage positive change. We provide innovative digital tools, life coaching, live trainings, and virtual support groups for you to learn, practice, and thrive.

WORK-LIFE SERVICES

Unlimited live telephonic consults are available with our work-life specialists who will assist you in resolving concerns by offering resources and referrals related to: • Childcare & Parenting • Eldercare & Caregiving • Financial Stress • Legal Concerns • Education Planning • Convenience Services

DIGITAL TOOLS & RESOURCES

Not sure you want to reach out to talk to anyone about your concerns? AllOne Health offers a wide variety of digital tools to support your mental health and work-life needs on your own, including: • Self-assessment tools • Live mindfulness practice • Podcasts, articles, and education • On-demand videos and webinars • Virtual support groups

Wellness

ISAC's Wellness Program runs from January 1, 2026 through October 31, 2026. Employees will have the opportunity to earn up to \$364 in wellness incentives. These incentives will be disbursed through your paycheck at the end of the calendar year and through payment by VOYA.



Incentive Amount	Task
\$100	Physical / preventive exam with doctor-completed fax form (reimbursed through VOYA Accident Insurance)
\$25	Online Assessment
\$25	Mental Health Training
Up to \$214	Step Challenge: Earn \$1/day for walking 10,000/day OR \$0.50/day for walking 7,500+/day March 1 – September 30th

Members have access to the Online Wellbeing Program at ISAC.livehealthyignite.com

Log in and Enhance Your Health:

- Complete program activities and earn your incentive.
- Participate in personal wellbeing challenges.
- Browse a database of recipes and workout videos.
- Fill out a meal planner and search for local grocery store discounts.
- Track health-related activity: step count, activity minutes, nutrition, hydration, sleep and weight. You can enter this information manually, with the Navigate Wellbeing app or by syncing your favorite devices and apps, which will update on the portal each day.

Employee Contributions

EMPLOYEE GROUP LIFE is 100% Employer paid.

Contribution information is based on 26 payroll deductions per year.

MEDICAL

Cost Per Pay	\$500 PSF PLAN
Employee Only	\$45.90
Family	\$179.79

DENTAL

Cost Per Pay	DELTA DENTAL
Employee Only	\$10.85
Family	\$25.85

VISION

Cost Per Pay	DELTA VISION
Employee Only	\$1.43
Family	\$3.64

ACCIDENT

Cost Per Pay	CORE (med enrolled)	ENHANCED (med enrolled)		CORE (med waived)	ENHANCED (med waived)
Employee Only	\$0	\$2.79		\$3.28	\$6.06
Employee + Spouse	\$1.64	\$8.70		\$4.92	\$11.97
Employee + Child(ren)	\$4.06	\$9.58		\$7.34	\$12.86
Family	\$5.70	\$15.49		\$8.98	\$18.77

CRITICAL ILLNESS

**Employee and spouse: \$12.30 (each) per \$10,000 per month;
Child(ren) are automatically covered with employee enrollment**

VOLUNTARY LIFE

See Employee Navigator for Rate Information



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