North Cedar Community School District

Employee Health Plan Guide

July 1, 2022 – June 30, 2022

Eligibility & Enrollment

Who Is Eligible

If you're a full-time employee you're eligible to enroll in the benefits outlined in this guide. Full-time employees are those who work 30 or more hours per week. In addition, the following family members are eligible for medical, dental and vision coverage:

- Spouse
- Children under the age of 26

How to Enroll

You will use the Ease on-line enrollment platform to enroll in medical benefits. When you are ready to enroll, the first step is to review your current benefits. Did you move recently or get married?

Once all your general information is up to date, it's time to make your benefit elections. The decisions you make during open enrollment can have a significant impact on your life and finances, so it is important to weigh your options carefully.

Check out the "Enroll with Ease" page for more information on how to use the Ease online enrollment platform.

When to Enroll

Our Open Enrollment Period begins **today** and closes May 27, 2022.

The benefits you choose during this open enrollment period will become effective on July 1, 2022.

How to Make Changes After Open Enrollment

Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period. Qualifying events include things like:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child or other qualified dependent
- Change in residence
- Change in employment status or a change in coverage under another employer-sponsored plan

Enroll with Ease

Enrolling in benefits will be easy and efficient when you use our on-line enrollment platform called "Ease".

Using Ease will streamline our HR processes, reduce wait time and lower the chance for data entry errors.

Read through the instructions below so you know what to expect when enrolling with Ease.

What can you expect from Ease?

You will be receiving an email when it is time to enroll. Please follow the instructions given.

1. *There will be a blue "login" button. Click on that button to be taken to your account.*
2. *You will be asked to select a password, and to "sign up".*
3. *From there you will be taken to your dashboard. From there you will have access to our document library, a portal to manage your benefits, and the ability to view your profile.*
4. *Start by reviewing the documents in the document library.*
5. *Once open enrollment begins, you will see a yellow bar at the top of the screen with a green button to "start enrollment". Click this button when you are ready to enroll in benefits for the upcoming year.*
    - *You will be directed to review your profile information for accuracy*
    - *Use the "next" and "back" buttons to navigate through ease*
    - *For each benefit, you will be given the option to "waive" or "covered" by sliding the button (grey for waiving, green for coverage)*
    - *If there are multiple plans offered, you will need to click next to the benefit you would like to view or enroll. For more benefit information, click "show" under details. The cost of each benefit premium will be shown here as well.*
6. *After you have completed your enrollment and electronically "signed" your forms as prompted, you will be given the opportunity to review your enrollment. At this point, you will also be given the option to download or print your forms.*
7. *Once everything is complete and accurate, you will click "finish" and then click on your name in the upper right corner to log out.*

HEALTH PLAN
Wellmark Blue Cross Blue Shield of Iowa

830

Plan Code		Traditional Plan 1	Traditional Plan 2	HDHP Plan 3
Network		Alliance Select*	Blue Advantage**	Blue Advantage**
ACTUAL PLAN DESIGN				
Annual Deductible	Single	$5,000	$5,000	$5,500
	Family	$10,000	$10,000	$10,000
Coinsurance You Pay		50%	50%	0%
Out-of-Pocket Maximum	Single	$7,900	$7,900	$5,500
	Family	$15,800	$15,800	$10,000
BUY DOWN PLAN DESIGN				
Annual Deductible	Single	$1,000	$1,000	This plan does not offer the buy down option, instead a contribution would be made to your individual Health Savings Account (HSA).
	Family	$2,000	$2,000	
Coinsurance You Pay		20%	20%	
Out-of-Pocket Maximum	Single	$1,500	$1,500	
	Family	$3,000	$3,000	
COPAYS FOR COMMON SERVICES				
Preventive		$0	$0	$0
Primary Care Physician		$30	$30	Medical Deductible OPM applies first, once met the plan pays 100% of covered services.
Specialist		$60	$60	
Urgent Care		$30	$30	
Emergency Room		50% Coinsurance	50% Coinsurance	
PHARMACY				
Annual Rx Deductible	Single	$100	$100	Medical Deductible OPM applies first, once met the plan pays 100% of covered Rx.
	Family	$200	$200	
Tier 1		$10	$10	
Tier 2		$35	$35	
Tier 3		$80	$80	
Tier 4		$150	$150	
MONTHLY PREMIUM				
Employee only		$177.04	$90.00	$0.00
Employee + Spouse		$1,138.62	$933.24	$790.79
Employee + Child(ren)		$988.95	$798.98	$671.80
Family		$1,626.04	$1,370.44	$1,574.53

*As a general rule, out-of-network services will have a higher out of pocket cost when available. Emergency care, which is billed the same as if using an in-network provider, is an exception.

**Blue Advantage do not provide coverage out-of-network except in emergency situations. Doctor on Demand Virtual Visits are always in-network, and available for the same copay as an in-person visit

HMO vs PPO
Which Wellmark network is right for you?

Deciding Between an HMO and a PPO?

When you have a choice between these two types of plans, consider your medical needs. If you're looking at an HMO, take a close look at the network to determine if the choices of doctors and medical facilities are adequate to meet your needs. A PPO gives you more freedom, including the potential to be covered for medical bills incurred by providers outside of Iowa, but your premium cost may be higher.

HMO HEALTH INSURANCE PLANS

A Health Maintenance Organization (HMO) gives you access to certain doctors and hospitals within its network. Wellmark's HMO network is in Iowa only and is made up of providers that have agreed to lower their rates for plan members and also meet quality standards. Unlike PPO plans, care under an HMO plan is covered only if you see a provider within that HMO's network. There are few opportunities to see a non-network provider.

HMO key features:

- If you opt to see a provider outside of an HMO network, there is no coverage, meaning you will have to pay the entire cost of medical services unless the care is for EMERGENCY services. However, you do have access to care for certain conditions through Wellmark's Doctor on Demand (Virtual Health).
- Wellmark's HMO plans require you to select a primary care physician (PCP), and you must receive your preventive care from your PCP.
- Premiums are generally lower for HMO plans.

PPO HEALTH INSURANCE PLANS

Preferred Provider Organization (PPO) plans provide more flexibility when picking a doctor or hospital. They feature a broader, national network of providers. In addition, your PPO plan may pay if you see a non-network provider, although it will be at a lower rate in-network.

PPO key features:

- You can see a national network doctor or specialist you'd like without having to see a PCP first.
- You can see a doctor or go to a hospital outside the network and you may be covered. However, out-of-network benefits are subject to greater cost-sharing by the employee, which may be significant.
- Premiums tend to be higher than HMO plans.

Did you know?

92% of PPO claims that occur on Wellmark's PPO network in Iowa would have also been covered by Wellmark's HMO Network.

Sniffles while on vacation?

You're covered with Doctor on Demand Virtual Visits. Members can rest easy knowing that Doctor on Demand is in-network wherever they may roam!

	HMO	PPO
In Network Coverage Area	Statewide (Iowa)	Nationwide
Coverage in all 99 of Iowa's Counties	Yes	Yes
Coverage at 100% of Iowa Hospitals	No coverage at Medical Associates	Yes
Covers 98% of Iowa's Physicians	Yes	Yes
Access to Doctors on Demand (Virtual Health)	Yes	Yes
Must select and see a Primary Care Physician for Preventive Services	No	NO
Coverage outside of your network	Emergency Only*	Yes, at higher cost
Ability to go to the MAYO clinic or other out-of-state providers (unless emergency)	No	Yes
Generally Lower Premiums	Yes	No

*A full-time student may obtain other than emergency coverage out of network with a guest membership.

The Advantages of a Health Savings Account (HSA)

Affordability:	In most cases, the health insurance premium for the HDHP should be less than premiums for a traditional PPO plan.
Portability:	✓ You can take any remaining HSA dollars with you, if you leave the company. ✓ The accounts are completely portable, regardless of whether the individual is employed or not, what employer the individual works for, resident state, age, or marital status.
Ownership:	Funds remain in your account from year to year, just like an IRA. There are no "use it or lose it" rules for HSA's- so they are a great way to save money for future medical expenses.
Tax Savings:	✓ Your contributions to the HSA may be made through pre-tax payroll deductions or through direct tax-deductible contributions. ✓ The 2022 maximum HSA contributions: $3,650 Single, or $7,300 for a Family. (An additional catch-up contribution of $1,000 may be made if 55-65 years of age) ✓ Tax free earnings through investments. ✓ Tax free withdrawals for qualified medical expenses.
Control:	✓ You can use the HSA to pay for any qualified medical expense, as defined by the IRS. There is no need for pre-authorization of services. ✓ Accounts are owned by the individual, not the employer. ✓ You decide how much money to put into the account (subject to IRS limits.) ✓ You decide whether to save the account for future expenses or pay current medical expenses. ✓ You decide which company/bank will hold the HSA account (unless the employer is contributing to the employee's HSA funds.) ✓ You track your own deposits and expenditures and retain your own receipts. You are ultimately responsible for proving how the account is used because it is individually owned.
Savings and Investments:	Unused HSA dollars remain in the HSA from one year to the next and can be invested for further growth. HSA accounts encourage savings for <u>future</u> medical expenses such as: ✓ When employer-sponsored coverage is lost during periods of unemployment, ✓ Medical expenses after retirement (before Medicare eligibility), ✓ Insurance coverage after Medicare eligibility (except Medigap), ✓ Out-of-pocket expenses for Medicare, ✓ Long term care expenses.
Over Age 65:	Once you turn 65, you can continue to use your account tax-free for out-of-pocket health expenses. If you enroll in Medicare, you can use the account to pay Medicare premiums, deductibles, copays, and coinsurance under any part of Medicare. If you have retiree health benefits through a former employer, you can also use the account to pay for your share of retiree medical insurance premiums. You <u>cannot</u> use the account to purchase Medicare supplemental insurance or a "Medigap" policy. Once you turn age 65, they can also use the account to pay for things other than medical expenses. If used for other expenses, the amount withdrawn will be taxable as income but will not be subject to any other penalties. Individuals under age 65 who use their accounts for non-medical expenses must pay income tax and a 20% penalty on the amount withdrawn.

Wellmark

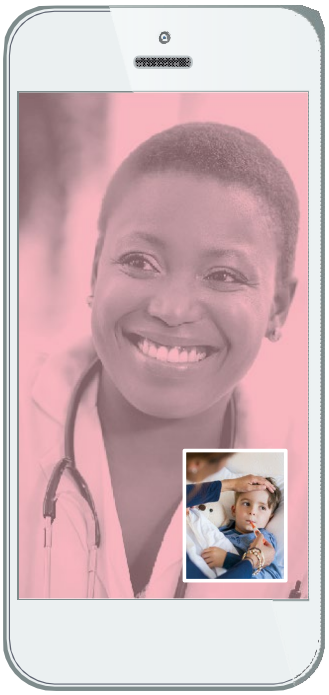
FEELING BETTER SHOULD BE EASY.

Visit a doctor on your smartphone, tablet or computer virtually anywhere, any time.

dr+ on demand

Getting started is easy.

- Download the Doctor On Demand® app or visit DoctorOnDemand.com.
- Have your Wellmark Blue Cross and Blue Shield member ID card ready.
- Create an account or sign in.



See a doctor in minutes

Getting sick is bad enough without having to get out of bed to see a doctor. With Doctor On Demand, you and your family members can connect face-to-face with a board- certified doctor on your schedule.

Get treatment for:

- Cold and flu
- Bronchitis and sinus infections
- Urinary tract infections
- Sore throats
- Allergies
- Fever
- Headache
- Pink eye
- Skin condition
- Other conditions such as mental health (if covered by your group health plan)[1]

[1] Mental health treatment cost share is subject to group plan coverage. Mental health coverage includes psychiatry services and medication management along with treatment for psychological conditions, emotional issues and chemical dependency. For more information, call Wellmark with the number on the back of your ID card.

QUESTIONS? CALL 800-997-6196.

Callers could experience longer wait times between 10 p.m. and 6 a.m. CST or may be directed to schedule an appointment in some instances.

Welcome

Wellmark is here to support you with:

Health

Wellness

Education

Resources

A guide to getting the most out of your health insurance

You are now protected by the trusted, national Blue Cross® and Blue Shield® network that **insures more than 100 million Americans.** As a leader in the health insurance industry for more than 80 years, **Wellmark® Blue Cross® and Blue Shield®** has built a reputation of providing quality health care coverage you can trust.

Our long-standing relationship with hospitals, physicians and other health care professionals allows us to give you more choices through our **large network of providers.** And, you get market-leading tools and services that make us easy to do business with, help you **manage your health care costs** and live a healthier life.

CONNECT WITH US

Table of contents

Making the most of your Wellmark benefits

The goal of this guide is to help you know how to engage with Wellmark before, during and after using your benefits so you get the most from your health plan. We're committed to providing education, tools and resources that help you improve your health and live a better life. This includes:

Saving money by staying in-network: Learn what a network is, the advantages of seeing in-network health care providers and how to find them in your network.

Knowing your plan details: Discover what products and services are covered before you see your doctor or visit the hospital.

Establishing a medical home: Cultivating a long-term relationship with a primary care provider (PCP) allows them to get to know you, your health history and your health needs.

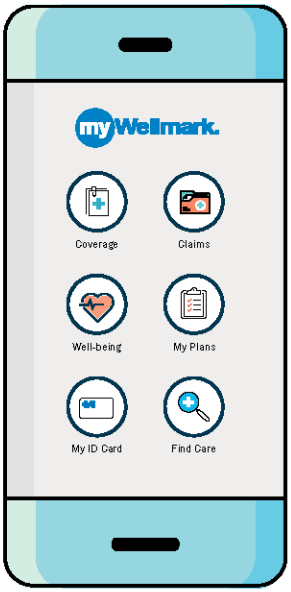
Accessing free tools and resources to maximize your benefits: You get self-serve digital tools, health and wellness support, and discounts exclusive to Wellmark members.

Focusing on the six elements of your well-being: Get tips to improve your physical, career, financial, social, community and emotional health.

This guide is not your official plan document, which provides specific details about covered and non-covered services. That information can be found by logging in to **myWellmark®** under Coverage Manual.

How to view your official plan documents

- Log in to myWellmark at **myWellmark.com**
- Click on the **My Plans** tab
- Or, go to **SBCCMFinder.Wellmark.com/Search**



For illustrative purposes only.

Register for myWellmark at myWellmark.com today.

Best of all? It's free.

Get started by setting up a myWellmark® account to unlock your benefits

myWellmark is the key to unlocking your personal health care information — no matter your location — with tools, resources and insights to help you manage health care spending and live a healthier life.

Use myWellmark, our secure online member portal, to:

- **Find information related to your specific benefits**
- **Estimate the cost of care for the most common procedures and services**
- **Find an in-network doctor or provider**
- **View recent claims and health care spending**
- **Access your digital ID cards**
- **Get electronic documents quickly and securely**
- **View your year-to-date spend report**
- **Get insights to manage your well-being**

Knowing your network saves you money

The term "in-network" health care provider describes practitioners, facilities or suppliers of health care services who Wellmark has made agreements with to give you the best prices possible. This means you won't be billed for differences between the provider's charge and our maximum allowable fee.

Network advantages for you

With Wellmark, you get access to one of the largest health care networks. You have the choice to use any doctor or hospital, but choosing an in-network provider has several advantages:

Lower out-of-pocket costs.

Physician referrals aren't required, so you can easily see specialists.

Waived deductibles for eligible office visits (unless you have a high-deductible health plan).

Your out-of-pocket costs apply toward your deductible or out-of-pocket maximum.

In-network providers handle claim filing and precertification tasks for you.

In or out of network, you are always covered in the case of an emergency. However, you can avoid higher out-of-pocket expenses by visiting your PCP or an urgent care provider for more minor, non-emergency situations.

By staying in network, you get the best possible:

Doctors

Hospitals

Prices

Looking for more ways to pay less for your health care?

Discover the simplest way to keep your costs down.

Wellmark Blue PPO℠ network

Your network is the Wellmark Blue PPO℠ network, our preferred provider organization (PPO), which gives you the broadest access to health care providers. With this network, you also get access to our national BlueCard® program that enables members of one Blue Cross and Blue Shield plan to obtain health care services while traveling or living in another service area.

Coverage across the United States

With the BlueCard program, you only pay the provider the usual out-of-pocket expenses (non-covered services, deductible, copay or coinsurance) when you use participating BlueCard providers across the country.

Coverage across the world

If you need medical assistance outside the United States, all you need to do is show your Wellmark ID card at participating Blue Cross Blue Shield Global® providers.

Wellmark Blue PPO offers you:

Dependability

Freedom

Convenience

How to receive coverage outside the United States:

- Verify what your international benefits are with Wellmark before leaving the country.
- In an emergency, go directly to the nearest doctor or hospital, then call the BlueCard Access® number on your ID card if you're admitted.
- For non-emergency inpatient medical care, call BlueCard Access to facilitate hospitalization at a Blue Cross Blue Shield Global provider.
- Call the number on your ID card if precertification or prior authorization is necessary.

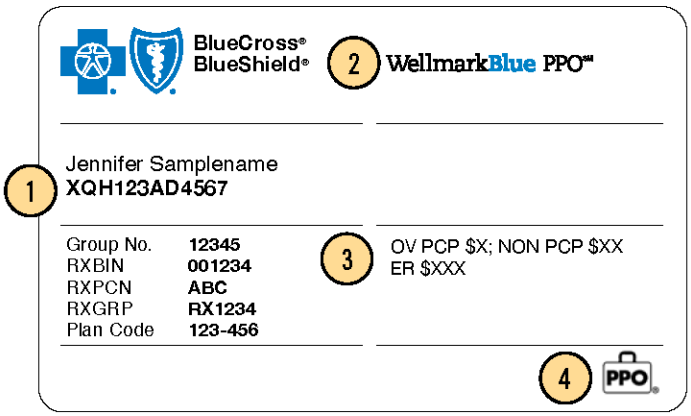
Show your Wellmark ID card at home and abroad

This helps ensure providers bill you appropriately. Your Wellmark ID card shows:

1. Every contract holder has an identification number. It starts with a three-character prefix that identifies your Blue Cross and Blue Shield plan and is followed by your personal identification number.
2. The name of your health plan appears here.
3. The amount you pay each time you receive services from a PPO provider. Refer to your Summary Plan description for more details.
4. This logo identifies you as a BlueCard PPO® member.

The back of your ID card includes information to:

1. Assist you with health plan questions.
2. Locate a provider in any state.
3. Notify Wellmark before receiving home health care services or admissions to a facility.
4. Get your health care and wellness questions answered around-the-clock.



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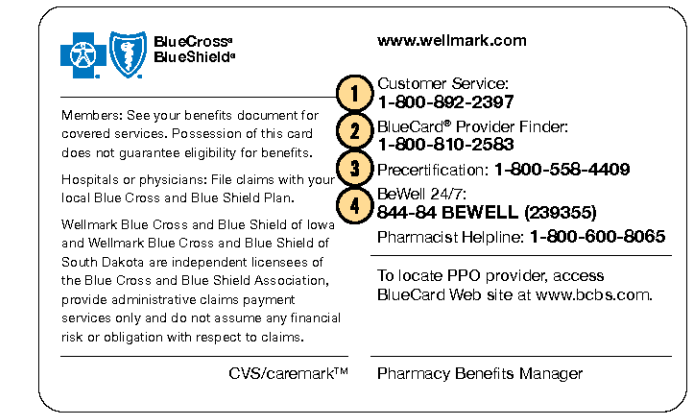

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For illustrative purposes only. Depending on your plan details, phone numbers may be different and there could be more or less information on your Wellmark ID card.

Better health outcomes, less hassle with a primary care physician (PCP)

Before you see a provider, consider selecting a **personal doctor**, also referred to as a primary care physician. Your PCP can play a major role in helping you manage and coordinate your health care needs. Advantages include:

Establishing a long-term relationship with a single health care provider who knows or will get to know you, your health and your health history.

Managing your health care needs and maintaining your medical records.

Assisting with a wide range of medical conditions and committing to improving your health.

Referring you to another in-network provider.

Find the best in-network providers

Locate in-network providers in **myWellmark** by selecting the **Find Care** tab or by calling **BlueCard Access at 800-810-BLUE (2583).**

Find participating Blue Cross Blue Shield Global doctors and hospitals at **BCBSGlobalCore.com**. Just enter the first three letters from your Wellmark ID card number and then select login. You can also call the same BlueCard Access number listed above.

See patient reviews and rate providers on myWellmark. All reviews are confidential, and providers won't know if or how individual members rated them.

Looking for the best in specialty care?

You can search for top medical facilities that have earned the Blue Distinction® designation by having a proven history of delivering **higher-quality specialized** care and better overall patient results by meeting strict, pre-determined quality standards developed by medical experts and providers.

Select **Find Care** in **myWellmark** and look for the **Find a Blue Distinction Center** link.

This page applies only to those who enroll in the HMO plan.

Wellmark Health Plan of Iowa

Your network is the Wellmark Health Plan of Iowa network. This network gives you access to 100 percent of hospitals and 98 percent of doctors in Iowa[1] and requires you and any covered family members to designate in-network primary care physicians (PCPs), also referred to as a personal doctor.[2]

Better health outcomes, less hassle with a PCP

Your PCP can play a major role in helping you manage and coordinate your health care needs. Advantages include:

Establishing a long-term relationship with a single health care provider who knows or will get to know you, your health and your health history.

Managing your health care needs and maintaining your medical records.

Assisting with a wide range of medical conditions and committing to improving your health.

Referring you to another in-network provider.

In or out of network, you're always covered in the case of an emergency. However, you can avoid higher out-of-pocket costs by visiting your PCP for minor, non-emergency situations.

[1] Wellmark Blue Cross and Blue Shield network numbers as of May 2020.
[2] Depending on your plan, in certain situations PCPs may not be required. Consult your plan document for your plan details.

Did you know only 61% of millennials have a PCP compared to 91% of Gen X?

How to select or change your PCP

- Select a PCP from our list of in-network general/family practice physicians, internists, nurse practitioners, physician assistants, or pediatricians.
- Your PCP can evaluate your medical condition and either treat you or coordinate specialty care. Female members can also designate an in-network OB/GYN for gynecological services. Benefits for preventive services are only available when performed by your designated PCP or OB/GYN.
- You can change your PCP or OB/GYN designation at any time at **myWellmark.com** by going to 'My Plans' and scrolling to the 'My Providers' section where you can add or change your provider as needed.

Find the best in-network providers

Locate in-network providers by visiting **myWellmark** and selecting the **Find Care** tab.

You can also see patient reviews and rate providers yourself. All reviews are confidential, and providers won't know if or how individual members rated them.

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Get coverage out-of-state with Guest Memberships

Guest Memberships allow you and your covered dependents to receive services from participating Blue Cross and Blue Shield hospitals and health care providers when traveling or residing outside Iowa, but still within the United States, for at least 90 consecutive days.

Guest Memberships are a valuable benefit for:

- Dependents attending school out of state, full-time, in an accredited institution.
- Members traveling for at least 90 consecutive days.
- Family members who reside in another state but are covered under the same health plan.

How to request and use your Guest Membership:

1. Call Customer Service at the number on the back of your ID card if you or your dependent will be living away from home for at least 90 consecutive days.
2. Locate and use in-network providers by calling 800-810-BLUE (2583) or by visiting bcbs.com and searching for providers in the BlueCard Traditional network.
3. Always present your Wellmark ID card upon receiving services.
4. Call the number on your ID for inpatient admissions, home health services, hospice services, private duty nursing and home infusion therapy as they require precertification.
5. Contact your employer to switch plans if you change your permanent residence from Iowa.
6. Call or email Customer Service for address changes or when you return to Iowa.
7. Only use non-emergency benefits for the state where you signed up for Guest Membership.

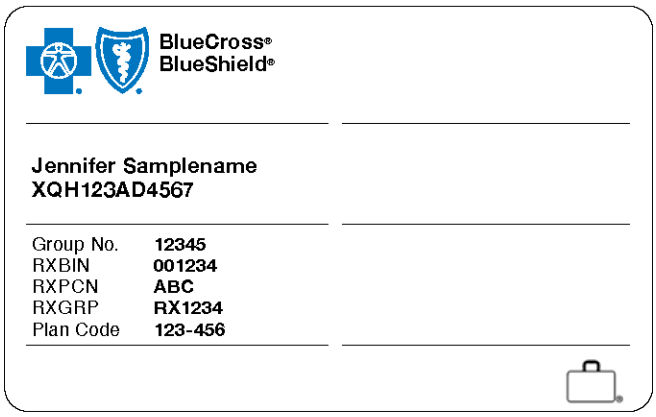
This page applies only to those who enroll in the HMO plan.

Show your Wellmark ID card in and out of Iowa

This helps ensure providers bill you appropriately.

When you receive care at a participating BlueCard hospital, show your ID card to receive these advantages:

- The physician or hospital will file the claim for you.
- All participating doctors and hospitals are paid directly.
- Participating providers agree to accept payment arrangements of the Blue Plan in their home state, which may result in a savings to you.



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For illustrative purposes only. Depending on your plan details, phone numbers may be different and there could be more or less information on your Wellmark ID card.

Your ID card is the link to emergency care when you're away from home.

To be eligible for benefits, show your ID card to any Blue Plan participating hospital or physician.

Visit DoctorOnDemand.com or your app store to register and download the app for free today!

4.9 stars from more than 28,500 customers with more than 1 million visits

Virtual visits offer you fast, convenient and safe care

Feel like you don't have time to go to the doctor? With Doctor On Demand®, you can video chat with a board-certified doctor from virtually anywhere using a smartphone, tablet or computer on your schedule — all for less than or equal to the cost of an office visit.[1]

Why see a doctor online?

- Less waiting — with an average wait time of under 10 minutes
- Costs less than or equal to an office visit
- No need to leave home or work to see a doctor
- 4.9 star rating out of 5 from more than 28,500 customers with more than 1 million visits

Visit Doctor On Demand and get prescriptions[2] for:

- Cold and flu symptoms
- Bronchitis and sinus infections
- Urinary tract infections
- Sore throats
- Allergies
- Fever
- Headaches
- Pink eye
- Skin conditions
- Mental health concerns[3]

[1] Costs may vary depending on your benefit selections. Check your plan documents in myWellmark to verify virtual visit costs for your plan.

[2] Doctor On Demand physicians do not prescribe Schedule I-IV DEA Controlled Substances and may elect not to treat or prescribe other medications based on what is clinically appropriate.

[3] Mental health treatment is subject to group plan coverage. Mental health coverage includes psychiatry services and medication management along with treatment for psychological conditions, emotional issues and chemical dependency. For more information, call Wellmark at the number on the back of your ID card.

Get the most from your pharmacy benefits

With drug costs continuing to rise, our integrated medical and pharmacy programs focus on drug safety, effectiveness and cost reduction — without sacrificing performance — in order to reduce your overall health care costs. Our ultimate goal is to get you the best and safest care for your dollar.

That's why your drug plan with Wellmark is simple and straightforward. There are different coverage levels depending on what "tier" a drug is assigned to on the Wellmark Drug List. The lower the tier, the lower you pay out-of-pocket.

The **Wellmark Drug List** of generic and brand-name drugs helps guide you and your providers to select the most appropriate medication for the best price. It's formed and updated by a team of doctors and pharmacists who review new and existing drugs and select them based on safety and effectiveness for treating a specific condition. They also evaluate drugs on how effective they are compared to similar drugs used to treat the same condition, all which help determine the drug tier.

Updates to the Wellmark Drug List happen regularly, as new drugs become available or drugs move tiers. If you take a drug on a regular basis, you may be notified when a change takes place. You'll want to double check the Wellmark Drug List if you get a new prescription or switch medications.

Ways to save on prescription drugs

Ask for generics. Generic drugs contain the same ingredients as brand-name drugs but typically cost much less. Even if a brand-name drug doesn't have a generic equivalent, a similar drug may be available to treat your condition.

Choose an in-network pharmacy. This is another easy way to maximize your savings. Upon arrival, just present your Wellmark ID card to the pharmacist.

Mail order pharmacy service. If you take a medication regularly, you can save some gas and a trip to the pharmacy by choosing to have drugs delivered to your home.

How to enroll in mail order pharmacy service

1. **Ask your doctor to write two prescriptions,** one for an initial short-term supply (e.g., 30-days) you can fill immediately at a participating retail pharmacy and a second for the maximum days' supply allowed by your plan, plus refills.

2. **Register with the mail order pharmacy in one of three ways:**

   - **Online** at **Wellmark.com/forms,** where you'll also find the forms you need to enroll by phone or fax.
   - **Mail:** Complete a Registration and Prescription Order form and submit it with your first prescription order.
   - **Phone:** Call the mail order pharmacy at 866-611-5961. Hours are Mon. – Fri., 7 a.m. – 9 p.m. CT, Sat. 7 a.m. – 4 p.m. CT.

3. **Refill prescriptions** by mail, phone or online once you've registered.

Specialty drugs and pharmacies

Specialty drugs are medications designed to treat conditions like multiple sclerosis, rheumatoid arthritis, hepatitis C and others that require non-traditional medications and special handling, administration or monitoring.

You can learn what drugs are classified as specialty drugs on the **Wellmark Drug List** by searching for the specific drug name or just by viewing the Specialty Drug List. It's important to know your medical benefits cover these drugs, not your pharmacy benefits.

Specialty pharmacies are experts in supplying specialty drugs and services to patients. You can work with a specialty pharmacy to have your medications delivered directly to your home, office or local CVS pharmacy. They can also provide you educational materials about your condition and the medications that have been prescribed to you, including 24-hour access to pharmacists.

Your plan may require you to purchase specialty drugs at a specialty pharmacy. If a participating specialty pharmacy is not used, you may be responsible for the full cost of the prescription. There are no additional costs for shipping and handling.

Check your plan documents for pharmacy benefit details with **myWellmark** by selecting the **My Plans** tab.

Get free prescription drug tools

Find the name of your prescription drug plan, what drugs are covered, their tier and what they'll cost you at **myWellmark.** You can also use myWellmark to find in-network pharmacies, track your claims, find generic drugs and more.

If you're new to Wellmark or your benefits haven't gone into effect yet, you can also find the **Wellmark Drug List** on **Wellmark.com.**

How to order specialty drugs

- Call CVS Specialty® Pharmacy at 800-237-2767 Monday – Friday, 6:30 a.m. – 8 p.m. CT.
- Provide your doctor's contact information and your Wellmark ID card information.
- A representative will confirm the prescription and dosage with your doctor and make arrangements to get your order delivered.
- Your provider will work on your behalf to start your specialty drug therapy.
- Find additional instructions and enrollment forms at **Wellmark.com/forms.**

Free Wellmark tools and services

As a Wellmark member, you have access to free tools and resources to maximize your benefits. They're all designed to help you manage your health care costs and live a healthier life.

Take myWellmark on-the-go with the Wellmark mobile app

The Wellmark app gives you mobile access to your favorite myWellmark tools on your smartphone. Get the speed and convenience of:

- Checking pending and processed claims
- Instant access to your specific plan details
- Digital ID cards, available to print, download or email
- Finding in-network care and cost estimates on-the-go
- Access to electronic documents, including your explanation of benefits

Know your out-of-pocket costs with your Explanation of Benefits (EOB)

An EOB is a recap of what your health plan has paid. Your EOB is not a bill. However, it's important to review it to make sure you have been (or will be) billed correctly, as it details:

- The amount your provider charged for each service.
- How much your health plan paid for each service.
- The amount you saved by staying in-network.
- Any out-of-pocket costs that the provider will bill you for separately.

How to download the app

1. **Download the app** at **myWellmark.com** or by searching for Wellmark in your app store.
2. **Open the app** and **select myWellmark.**
3. **Log in** using your myWellmark user ID and password.

How to read your EOB and get it online

Confused about your EOB? Learn more at: **Wellmark.com/EOB.** You can also go paperless and get your EOBs delivered to you immediately in four easy steps.

- **Register or log in** at **myWellmark.**
- **Select Profile** from the menu at the top.
- **Click Notifications.**
- Select your preferences and **click Agree & Save.**

Get member discounts and savings with Blue365®

Blue365 lets you take advantage of discounts and savings on health care resources, healthy living programs, recreation and travel, as well as get access to helpful information for dependents or parents in need of caregivers and resources for your financial well-being.

Blue365 also offers you access to savings on products and services for healthy lifestyles. One of the most popular discounts is Tivity Health® Fitness Your Way. This discount provides access to more than 8,000 participating fitness centers nationwide including Anytime Fitness®, Curves® and Snap Fitness™, and certain Gold's Gyms® and YMCA®s.

Receive healthy tips and plan updates with *Blue*℠ magazine

Blue is our member magazine that keeps you informed on health plan updates and delivers the latest in health and wellness information. You can find all of the stories and more online at **Wellmark.com/Blue.**

Get more with the *Blue* e-newsletter

Sign up for the monthly e-newsletter to get exclusive information more often, with links to helpful content, like videos and recipes. Visit **Wellmark.com/Blue** to subscribe today. You can also follow us on any of your favorite social media platforms at WellmarkBCBS. It's just one more way Wellmark members get more.

CONNECT WITH US

How to register

Register for Blue365 at **Blue365Deals.com/WellmarkBCBS,** choose Fitness and find Fitness Your Way. Follow the instructions to redeem the offer to get all the discount details, including what gyms are participating in your area. Blue365 discounts are only available online.

It's so much more than a nurse line. No matter your concern, someone is ready to help at 844-84-BEWELL (239355).

Get real help from real people with BeWell 24/7℠

Life can get pretty stressful. Like when your toddler has a fever at midnight, you're coordinating care for an elderly parent who lives out of town, or you're having side effects from a new drug and don't know what to do. Luckily there's BeWell 24/7.

When you call BeWell 24/7, you'll be connected with a real person who can help you with a variety of health-related concerns. For example:

Discuss treatment options and answer your health and wellness questions.

Make arrangements for community-based services for yourself or a family member, like in-home safety modifications, meals, medical equipment, transportation and more.

Coordinate health care appointments, including in-home health help and record retrieval.

Locate health care providers and facilities — whether you're at home or traveling.

Estimate your costs for common medical procedures and services.

Free Wellmark health services

Wellmark also offers free health services to get you engaged with your health. We collaborate with your health care provider to help you use and navigate the health care system so you get the right care at the right time and place.

You get:

- Advice from real clinicians with real-world experience.
- Personalized support from a single point of contact.
- Access to an integrated care team.

Our health services teams help you stay well and access preventive care, identify gaps in care, and navigate and coordinate care. This proven, tailored approach for each individual effectively improves your health outcomes by assisting you before, during and after you receive care — and helps reduce your burden and total costs.

Condition Support — for members who need extra care

Facing a new or ongoing health condition doesn't mean you have to approach the diagnosis on your own. Our Condition Support team helps you make sense of the medical jargon, supports your provider's plan of care and makes it work for you. A nurse talks with you over the phone to teach you skills to help manage your condition and offers education to inform and empower you to help with illnesses like:

- Diabetes
- Asthma
- Heart disease

The level of support you receive is based on how well you're managing your condition and the goals you'd like to reach. Participation is voluntary and free.

Three ways you can join the Condition Support program:

- You may voluntarily enroll in the program by calling BeWell 24/7.
- You may be identified through your claims and contacted by Wellmark via mail or phone.
- Your doctor may refer you to the program and then you'll be contacted via mail or phone.

ENROLL NOW: Call BeWell 24/7 at 844-84-BEWELL (239355) to connect to helpful resources and enroll in the condition support program.

This health support program is not a substitute for patient care or treatment by a physician. Check with your employer to see if these services are available to you.

Extra help when (and if) you need it most with Rare Condition Management

Our Rare Condition Management program offers comprehensive care for members with rare and complex conditions. Some examples include Amyotrophic Lateral Sclerosis (ALS), Chron's disease and Parkinson's.

The program is meant to alleviate emotional, physical and financial burdens by preventing an increase in emergency care, hospital visits, use of unnecessarily high-cost medications and more. Eligible members are identified and contacted by a specialized nurse who has training for each individual condition and serves as an advocate to provide holistic and proactive support.

Whether you need a lot of support, or you just have a question now and then, the program is tailored to your needs. Along with one-on-one phone support, you'll have digital tools to help you keep track of your health.

When Wellmark calls, should you answer?

The answer is yes.

A nurse or health support team member may call to help and give you important information.

- **Discharge outreach.** Wellmark's health assistants may contact you within two days of a hospital discharge. The purpose of this call is to make sure you are on the path to recovery and have not experienced any new symptoms.
- **Health advocacy.** Our health assistants also may call to provide you with benefits or health information. For example, you may get a call if there has been a change that might impact your expenses or to remind you about a preventive exam you may need.
- **Advanced care.** We want to help coordinate care for you and help you overcome barriers you may be facing during your recovery from severe or complex conditions, such as a stroke or brain injury. We will talk through in-home care, meal delivery and other support.

Find out if you're eligible for Rare Condition Management

Just call us at the number on the back of your Wellmark ID card.

Supporting healthy pregnancies

Pregnancy can be wonderful — it can also be overwhelming. Our Pregnancy Support Program provides resources to help our members have a healthy, stress-free pregnancy through each stage and beyond.

We've partnered with some of the most trusted resources to provide helpful information, including:

WebMD® pregnancy assistant — Learn about the stages of your baby's growth and get support throughout the pregnancy from prenatal to postpartum.

Count the Kicks® — Keep track of your baby's normal movement patterns in the third trimester.

Text 4 Baby℠ — Learn about baby milestones, set appointment reminders and get safety information via text message.

Access to nurses — Rather receive support throughout your pregnancy over the phone? You can request a call from an Advanced Care nurse by calling 800-552-3993 ext. 3727.

BEWELL 24/7℠— Call 844-84-BEWELL to connect with a real person who can answer your most pressing questions. We'll take the time to listen to and address all your concerns.

Online pregnancy assessment — Go to myWellmark and enter your health history and current pregnancy information to see if you may benefit from nurse support over the phone.

Sign up via myWellmark

These trusted and helpful online resources are available when and where you need them at **myWellmark** by going to the **Well-being** tab.

A journey to a healthier you

Wellness is about taking a look at the bigger picture, which includes your physical health, career, finances, social interactions, mental health and community involvement.

Get started on your well-being journey by going to **myWellmark** and selecting the **Well-being tab.** There you can make progress toward your goals with access to a wellness assessment, health trackers, Blue365 discounts, as well as various blogs and whitepapers through a leading health expert — **WebMD®.**

The best way to get the most value out of your health insurance? Taking care of yourself

You're probably aware of the traditional ways of maintaining good physical health: eating right, exercising frequently, and getting annual health screenings and immunizations. But evidence has proven that by taking a holistic approach to well-being, health-related costs drop a whopping 41 percent.

That's why Wellmark is here to help you focus on the six holistic elements of your well-being:

Physical — When you feel better physically, you're happier, healthier and spend less time and money at the doctor's office.

Career — It's important to your health to be able to use your strengths at work and understand how what you do ties to your organization's business goals.

Financial — Nearly 78 percent of Americans are living paycheck-to-paycheck. Look into programs to help you trim debt or save money, they can help ease your mind.

Social — Relationships between friends, family and coworkers can help define who you are and how you feel. So make the time to improve your social well-being for better health.

Community — 77 percent of Americans believe volunteering is essential to their overall well-being. Find opportunities to give back by volunteering for a cause you care about.

Emotional — Being emotionally grounded is essential to leading a happy and productive life. Get the resources and support you need to improve your emotional and mental health.

Now, more than ever, people are looking for ways they can stay and remain healthy throughout the year. Taking care of the six elements of your well-being is a great way to start — and we're always here to help.

Resources

Use the links and phone numbers below to take advantage of all of the resources available to you as a Wellmark member.

BCBSGolbalCore.com: Find participating Blue Cross Blue Shield Global doctors and hospitals by entering the first three letters from your Wellmark ID card number and selecting login.

BeWell 24/7: Get real help from real people 24/7 at 844-842-3935. With BeWell 24/7 you have access to health advocacy, nurse support and care navigation.

Wellmark.com/Blue365: Wellmark members receive exclusive access to discounts and resources that help you live a healthier lifestyle. Simply use your Wellmark ID card to browse the healthy deals and daily offers at Wellmark.com/Blue365.

Wellmark.com/Blue: Our member magazine keeps you informed on health plan updates and delivers the latest in health and wellness information.

DoctorOnDemand.com: You and your family members can see a board-certified doctor from virtually anywhere using a smartphone, tablet or computer for the most common medical conditions and receive prescription medication, if needed. Download the app from the App Store or get it on Google Play.

myWellmark.com: Your personal health care information is at your fingertips with myWellmark — no matter your location — with tools, resources and insights to help you manage health care spending and live a healthier life.

Wellmark app: Take myWellmark on-the-go by downloading the Wellmark app from your app store. It gives you mobile access to your favorite myWellmark tools on your smartphone.

Wellmark.com: Find prescription drug information, tips on maximizing your health coverage, ways to live a healthier life and more.

Wellmark.com/forms: Search for claims, pharmacy and any other forms you may need.

Wellmark Drug List: Say your doctor prescribes a new medication, and you want to make sure your plan covers it before you commit. The Wellmark Drug List gives the drug name, category, tier and what special authorization is required for all the prescription drugs our plans cover.

Required Federal Accessibility and Nondiscrimination Notice

Discrimination is against the law

Wellmark complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Wellmark does not exclude people or treat them differently because of their race, color, national origin, age, disability or sex.

Wellmark provides:

- Free aids and services to people with disabilities so they may communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call 800-524-9242.

If you believe that Wellmark has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Wellmark Civil Rights Coordinator, 1331 Grand Avenue, Station 5W189, Des Moines, IA 50309-2901, 515-376-4500, TTY 888-781-4262, Fax 515-376-9073, Email CRC@Wellmark.com. You can file a grievance in person, by mail, fax or email. If you need help filing a grievance, the Wellmark Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail, phone or fax at: U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F, HHH Building, Washington DC 20201, 800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意：如果您说普通话，我们可免费为您提供语言协助服务。请拨打 800-524-9242 或（听障专线：888-781-4262）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 800-524-9242 أو (خدمة الهاتف النصي: 888-781-4262).

ຂ້ອຽ:ຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາ ໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ຫາ. (TTY: 888-781-4262.)

주의: 한국어 를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें : अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, निःशुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

ATTENTION : si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deitsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

ဘာသာစကားသတိပြုရန်,ကရင်ဘာသာစကားပြောပါကအခမဲ့ဘာသာစကားအကူအညီဝန်ဆောင်မှုများကိုသင့်အတွက်ရရှိနိုင်ပါသည်။ခေါ်ဆိုရန် 800-524-9242 (TTY:888-781-4262)။

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: यदि तपाई नेपाली बोल्नुहुन्छ भने, तपाईका लागि निःशुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस्।

ማሳሰቢያ: አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ እገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም (በTTY: 888-781-4262) ይሙሉ ያነጋግሩን።

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maaɗa. Heɓir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNAA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) quunnamaa.

УВАГА! Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телетайп: 888-781-4262).

Ge': Dlné k'ehjí yáníłtí'go níká bízaad bee áká' adoowoł, t'áá jíík'é, náhóló. Koji' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)

REQUIRED ANNUAL NOTICES

- Marketplace Notice
- Special Enrollment Periods
- COBRA Notice: Continuation Coverage Rights Under COBRA
- Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices and Special Enrollments Rights Notice
- Patient Protection Choice of Providers
- Women's Health Care Rights Act (WHCRA) and Newborn's and Mothers Health Protection Act (NMHPA) Notices
- Children's Health Insurance Program (CHIPRA) Notice
- Notice of Creditable Coverage – aka Medicare Part D Notice
- No Surprise Billing Act

MARKETPLACE NOTICE

NOTICE TO NEW HIRES!

New Health Insurance Marketplace Coverage Options and Your Health Coverage

As of January 2014, health insurance can be purchased through the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Each year, the open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the previous year. After Dec. 15, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

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 9.5 percent (as adjusted each year after 2014) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.) **Note:** If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is 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 employer sponsored plan's administrator. 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, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

SPECIAL ENROLLMENT PERIODS

NOTICE TO ALL EMPLOYEES

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

Loss of Other Coverage

If you are declining coverage 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).

Example: You waived coverage under this Plan 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 Plan.

Marriage, Birth or Adoption

If you have a new dependent as a result of a 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.

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 Plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance 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 coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

For More Information or Assistance

To request special enrollment or obtain more information, please contact your plan's administrator.

COBRA NOTICE
Continuation Coverage Rights Under COBRA

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 [*choose and enter appropriate information:* must pay *or* aren't required to 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."

The following applies only to retiree health plan offerings:

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [*enter name of employer sponsoring the Plan*], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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; *[add if Plan provides retiree health coverage:* Commencement of a proceeding in bankruptcy with respect to the employer;]; or The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

Continuation Coverage Rights Under COBRA

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 [*or enter longer period permitted under the terms of the Plan*] after the qualifying event occurs. You must provide this notice to: [*Enter name of appropriate party*]. [*Add description of any additional Plan procedures for this notice, including a description of any required information or documentation.*]

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. [*Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice.*]

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. https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

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.

HIPAA NOTICE
Health Insurance Portability & Accountability Act

HIPAA NOTICE OF PRIVACY PRACTICES

For information regarding your rights and our responsibilities regarding how your medical information may be used and disclosed and how you can get access to this information, please review the notice provided by your medical carrier or visit the Health and Human Services Website at www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

HIPAA SPECIAL ENROLLMENT RIGHTS NOTICE

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 you 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. To request special enrollment or obtain more information, contact your Employer Representative.

PATIENT PROTECTION CHOICE OF PROVIDERS

In cases where your employer's group health plan allows or requires a participant to designate a primary care provider, the participant has the right to designate any primary care provider who participates in the network and who is available to accept the participant or participant's family members.

Until you make this designation, your employer or health plan carrier may designate a primary care provider automatically. For information on how to select a primary care provider, and for a list of the participating primary care providers, you can contact your employer sponsored plan's administrator.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization in order to obtain access to obstetrical or gynecological care from a health care professional in your network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology contact your employer sponsored plan's administrator.

WHCRA & NMHPA NOTICES
Protection for Women and Newborns

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 (WHCRA) provides protections for individuals who elect breast reconstruction after a mastectomy. Under WHCRA, group health plans offering mastectomy coverage must provide coverage for certain services relating to the mastectomy, in a manner determined in consultation with the attending physician and the patient.

The required coverage includes:

- 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.

Under WHCRA, mastectomy benefits may be subject to annual deductibles and coinsurance consistent with those established for other benefits under the plan or coverage.

Group health plans, health insurance companies and HMOs covered by the law must provide written notification to individuals of the coverage required by WHCRA upon enrollment and annually thereafter.

Additional consumer information on WHCRA is available in the publication **Your Rights After A Mastectomy**.

Information for group health plans and employers on WHCRA and other health benefit law requirements is available in the publication **Compliance Assistance Guide – Health Benefits Coverage Under Federal Law**.

Newborn's and Mother's Health Protection Act

Group health plans and health insurance insurers 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 if applicable). In any case, plans and insurers 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).

CHIPRA NOTICE

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

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).

You may be eligible for assistance paying your employer health plan premiums, policies differ by state. The following list of states is current as of July 31, 2021. Contact your state's agency for more information on eligibility:

Iowa – Medicaid and CHIP (Hawki)				
Medicaid:	Website:	https://dhs.iowa.gov/ime/members	Phone:	1-800-338-8366
Hawk-i:	Website:	http://dhs.iowa.gov/Hawki	Phone:	1-800-257-8563
HIPP	Website:	https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp	Phone:	1-888-346-9562

Minnesota - Medicaid	
Website:	https://mn.gov/dhs/people-we-serve/children-andfamilies/health-care/health-care-programs/programsand-services/other-insurance.jsp
Phone:	1-800-657-3739

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

South Dakota – Medicaid			
Website:	http://dss.sd.gov	Phone:	1-888-828-0059

All Other States
There are additional states that are not listed here. You may view the full list on the Department of Labor's website. https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/chipra/model-notice.pdf

MEDICARE PART D
Notice of Creditable Coverage

Important Notice regarding your prescription drug coverage and Medicare Part D.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with North Cedar Community Schools 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. North Cedar has determined that the prescription drug coverage offered by Wellmark Blue Cross Blue Shield of Iowa 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 Wellmark coverage with North Cedar will not be affected. If you decide to join a Medicare drug plan and drop your current medical plan coverage, be aware that you and your dependents will be able to get this coverage back after an 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 North Cedar 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.

MEDICARE PART D
Notice of Creditable Coverage Continued

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

You may 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 Wellmark 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).

Contact--Position/Office:	Kelly Stillwagon
Address:	120 E North St | Stanwood, IA 52337
Phone:	563-942-3358
e-Mail:	kellystillwagon@north-cedarstu.org

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).

NO SURPRISE BILLING ACT

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network. **"Out-of-network"** describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit. **"Surprise billing"** is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

YOU ARE PROTECTED FROM BALANCE BILLING FOR:

EMERGENCY SERVICES

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

CERTAIN SERVICES AT AN IN-NETWORK HOSPITAL OR AMBULATORY SURGICAL CENTER

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

[*Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed model language regarding applicable state law requirements as appropriate*]

WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THE FOLLOWING PROTECTIONS:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact your plan's administrator or the U.S. Department of Health and Human Services for guidance.

Visit www.hhs.gov for more information about your rights under federal law.

Visit https://www.legis.iowa.gov/docs/publications/BF/1069201.pdf for more information about your rights under Iowa Laws.

HEALTH PLAN TERMINOLOGY

Annual Limit	Cap on the benefits your insurance company will pay in a given year while you are enrolled in a particular health insurance plan.
Claim	A bill for medical services rendered.
Cost Sharing	Health Care Provider charges for which a patient is responsible under the terms of a health plan. This includes deductibles, coinsurance and copayments.
Coinsurance	Your share of the costs of a covered health care service calculated as a percentage of the allowed amount for the service. Example: Ann's surgery cost is $7,000. She has a $2,000 annual deductible. Ann is responsible for the first $2,000 of allowed charges, and that amount is applied to the deductible. The carrier will cover 80% (coinsurance) of the remaining $5,000 and Ann will cover 20% or $1,000. The total member out of pocket expense for Ann's surgery is $3,000 (the deductible of $2,000 + coinsurance of $1,000).
Copayment (Copay)	A fixed amount you pay for a covered heath care service, usually when you receive the service. Copays often apply to office visits, emergency room visits, and prescription drugs.
Deductible	The amount you owe for covered health care services each year before the insurance company begins to pay. (For some services you would pay a copay in lieu of the deductible as noted above.) Example: John has a health plan with a $2,000 annual deductible. John falls off his roof and has to have three knee surgeries, the first of which is $1,500. Because John hasn't paid anything toward his deductible yet this year, the $1,500 surgery cost goes towards the deductible and John is responsible for 100% of this cost.
Dependent Coverage	Coverage extended to the spouse and children of the primary insured member. Age restrictions on the coverage apply to dependent children (usually covered to age 26).
Explanation of Benefits (EOB)	A statement sent from the health insurance company to a member listing services that were billed by a provider, how those charges were processed and the total amount of patient responsibility for the claim.
Group Health Plan	A health insurance plan that provides benefits for employees of a business.
In-Patient Care	Care rendered in a hospital when the duration of the hospital stay is at least 24 hours.
Insurer (Carrier)	The insurance company providing coverage.
Insured	The person with health insurance coverage. For group health insurance, your employer will typically be the policyholder and you will be the insured.
Open Enrollment Period	The time period during which eligible persons may opt to sign up for coverage under a group health plan or make changes to who is covered under the plan.
Out-of-Pocket Maximum (OPM)	The maximum amount you should have to pay for your health care during one year, excluding monthly premium. After you reach the annual OPM, your health insurance plan begins to pay 100% of the allowed amount for covered health care services or items for the rest of the plan year.
Outpatient Care	Care rendered at a medical facility that does not require overnight hospital admittance or a hospital stay lasting 24 hours or less
Participating Provider	A health care provider who has contracted with a particular insurance carrier or health plan to provide health care services to its members. Also known as in-network provider.
Premium	Amount of money charged by an insurance company for coverage
Preventive Care	Medical check-ups and tests, immunizations and other services used to prevent chronic illnesses from occurring.
Primary Care Physician (PCP)	A physician (family doctor/pediatrician, OB-GYN, etc.) who is responsible for monitoring and coordinating a member's overall care. Some managed care plans require the member to select a PCP when they enroll for coverage.
Provider	A clinic, hospital, doctor, laboratory, health care practitioner or pharmacy.
Qualifying Life Event	A life event designated by the IRS that allows you to amend your current plan or enroll in new health insurance. Common life events include marriage, divorce, having or adopting a child, and losing coverage elsewhere.
Qualified Medical Expense	Expenses defined by the IRS as the costs attached to the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.
Summary of Benefits & Coverages (SBC)	An easy-to-read outline that lets you compare costs and coverage between health plans.
Telemedicine	A form of technology based communication that allows a doctor and patient to communicate without being in the same physical location. This can be used to evaluate, diagnose and prescribe treatment for common illnesses in lieu of an office visit or urgent care visit.
Utilization	The extent to which a particular group uses a particular health plan or program.

NORTH RISK PARTNERS®

This guide contains tables that summarize certain provisions of the carrier plan(s) illustrated. Complete plan information is included in the legal documents and brochures that govern each plan, these documents are available upon request. If there is a difference between this handout and the legal documents, then the legal documents will govern.