North Cedar Community Schools

Employee Benefit Guide

July 2023 to June 2024

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 Monday, May 15, 2023 and closes Monday, May 22, 2023.

The benefits you choose during this open enrollment period will become effective on July 1, 2023.

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:

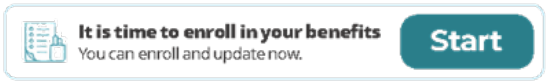
- Marriage, divorce or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child or other qualified dependent
- Change in residence
- Change in employment status or a change in coverage under another employer-sponsored plan

ease

9 Easy steps to employee enrollment.

1. Log in to Ease per the instructions you have received from your HR administrator or Broker.*

2. Click **Start**.



3. Follow the prompts on each page to complete your benefits enrollment — Click **Continue** to proceed to the next section.

4. Verify your personal information is correct and enter in any of your dependent information.

5. If requested during the enrollment process, provide any emergency contacts, employment documents, Medicare status, previous/current coverage and/or health information.

6. Select your benefit by choosing **Enrolled** ✓ or **Waived** ✗ for each plan — Click **Continue** to proceed to the next benefit.

7. You will then be prompted to provide any missing data. Once you have done this, you will be able to sign and review your forms using your mouse or mobile device.

8. Before you review your forms, you will need to first type your name, then sign your signature and follow the prompts to finish.

9. If you have questions, please reach out to your HR administrator or Broker.

*We recommend using either Google Chrome or Firefox as your browser for the optimal experience.

HEALTH PLAN
Wellmark Blue Cross Blue Shield of Iowa

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		$170.04	$90.00	$0.00
Employee + Spouse		$1,138.62	$933.24	$730.84
Employee + Child(ren)		$988.95	$798.98	$611.85
Family		$1,626.04	$1,370.44	$1059.82

*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

HEALTH SAVINGS ACCOUNT

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. ✓ **In 2023, the maximum HSA contributions will be $3,850 Single, or $7,750 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 Enrollment Guide Highlights

This guide was designed to help you know how to engage with Wellmark before, during and after using your benefits so that **you** get the most from your health plan. Wellmark is committed to providing education, tools and resources that will help you improve your health and live a better life. This includes:

- Saving money by using in-network providers.
- Knowing your plan details
- Establishing a medical home
- Accessing free tools and resources to maximize your Wellmark benefits
- Focusing on the six elements of your well-being.

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

- 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

Once you receive your Wellmark ID Card, register by visiting www.myWellmark.com.

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 that you won't be "balanced billed" for the differences between the provider's charge and Wellmark's maximum allowable fee. Out-of-Network coverage is very different on a PPO Network vs. an HMO Network. Make sure you know which network your plan offers to avoid surprise billing!

HMO vs PPO

Which Wellmark network is right for you?

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!

Need to Decide 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	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
Qualified Preventive Services covered at no cost to member	Paid at 100% In-Network No benefits out of network	Paid at 100% In-Network Out-of-network at higher Coinsurance
Coverage outside of your network	Emergency Only*	Yes, at higher cost
Coverage for Emergency Care	Same benefit in or out of network	Same benefit in or out of network
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. Contact Wellmark customer service at the number on the back of your ID card for details.

Finding a network provider.

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

You will also be able to see patient reviews and rate providers yourself. All reviews are confidential, and providers will not 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. Select Find Care in myWellmark and look for the Find a Blue Distinction Center link.

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

Your PCP can play a major role in helping you manage and coordinate your health care needs. The advantages of having a medical home 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 when you need specialized care.
- Female members can also designate an in-network OB/GYN for gynecological services.

BeWell 24/7

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

Virtual Visits with Doctor on Demand

When you're feeling ill, you may not want to sit in a waiting room. Or maybe you have traveled outside of your network or can't find a mental health provider in your area. Consider a virtual visit with a board-certified doctor from virtually anywhere using your smartphone, tablet or computer with Doctor on Demand. Fees are generally the same or less than the cost of going to the office, and you can get care where you feel most comfortable.

Visit Doctor on Demand and get prescriptions for:

- Cold and flu symptoms
- Bronchitis and sinus infections
- Urinary tract infections
- Sore throats
- Allergies
- Fever
- Headaches
- Pink Eye
- Skin Conditions
- Mental Health Concerns

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

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.

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.

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.

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.

Receive healthy tips and plan updates with BlueSM 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.

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.

- ✓ **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, and 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.

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 24/7SM— 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.

The best way to get the most value out of your health insurance is to take 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:

1. **Physical —** When you feel better physically, you're happier, healthier and spend less time and money at the doctor's office.
2. **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.
3. **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.
4. **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.
5. **Community —** Seventy-seven 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.
6. **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

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** to access the Wellmark Wellness Center. You can make progress toward your goals with access to a wellness assessment, health trackers, Blue365 discounts, and more.

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 Wellmark is always here to help.

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)

Understand your benefits.

EDUCATION MATTERS

Wellmark

STAY HEALTHY

Make an appointment for a preventive exam.

WHAT CAN YOU DO TO STAY HEALTHY AND PREVENT DISEASE?

Use your benefits and schedule preventive care screenings and exams with your personal doctor. Preventive exams are essential to your health. They can help identify a problem before symptoms begin and improve the chance that health conditions can be treated.

You can view a list of preventive care guidelines on Wellmark.com, which includes information on important exams, screenings and vaccinations. Talk to your doctor about which of these apply to you and when and how often you should be tested.

CHECK-UP CHECKLIST

Before your preventive exam, make sure you do these four things:

- **REVIEW YOUR FAMILY HEALTH HISTORY.** Are there any new conditions or diseases that have occurred in your close relatives since your last visit?
- **FIND OUT IF YOU ARE DUE FOR ANY SCREENINGS OR VACCINATIONS.** Have you had the recommended screening tests based on your age, health and lifestyle?
- **WRITE DOWN A LIST OF ISSUES AND QUESTIONS.** Review any existing health problems and note any changes.
- **CONSIDER FUTURE HEALTH ISSUES.** Do you want to lose weight or quit smoking? Discuss any issues that could affect your future health.

Centers for Disease Control and Prevention, 2009.

Not all Wellmark health plans include preventive benefits. Check your Coverage Manual or contact Customer Service to see what preventive care is covered by your plan.

P-20152 05/17 AN-T

Wellmark

GETTING STARTED WITH Rx mail service

The convenient, cost-effective way to get your prescription.

Have up to a 90-day supply of maintenance medication, including refills, mailed directly to you. No more lines, which saves you time.

Easily and conveniently enjoy delivery of your medications to your home, or other location of your choice, with CVS Caremark® Mail Order Pharmacy Services.

THINGS TO HAVE READY

1. Wellmark ID number
2. Name
3. Date of birth
4. Email address
5. New prescription for 90-day fill from your doctor

REGISTER AT CAREMARK.COM

(Accessible through myWellmark.com). Or, let CVS Caremark walk you through registration with FastStart® by calling 866-611-5961.

1. Visit Caremark.com and select **Register Now**.
2. Create a new, unique user ID.
3. Set up your mail order and contact preferences, such as auto refill, text alerts, and payment information.
4. Easily access your pharmacy information through Caremark.com and myWellmark.com.

SET UP MAIL ORDER

1. Select **Start Mail Service** under Prescriptions tab in your Caremark.com account.
2. CVS Caremark will accept your new 90-day prescription in a number of ways.
   a. Select **Request New Prescription** and complete the required information. CVS Caremark will then reach out to your doctor.
   b. Print the mail order form from your Caremark.com account and send that in along with a hard copy prescription.
   c. Call CVS Caremark at 866-611-5961, and a customer care representative will then reach out to your doctor.
   d. Your doctor can send in a new 90-day prescription to CVS Caremark.

Wellmark

FEELING BLUE?

VIRTUAL VISITS ARE HERE FOR YOU!

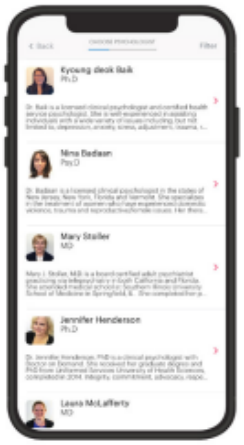
When it comes to coping with mental health, you are not alone. Virtual Visits can be available to you day or night from the comfort of your home.

MENTAL HEALTH.* It's a topic many avoid or are timid to discuss. But, according to NAMI.org (National Alliance on Mental Health):

1 in 5 adults are experiencing mental health issues.

60% aren't receiving the treatment they need.

dr. on demand



Review and choose your doctor

Comfortable, connected, confidential

As a part of your health benefits, you can connect with a licensed therapist — or psychiatrist for more complex issues — to listen and help you find solutions.

Ready when you are

Make time for you and your overall health and well-being by scheduling your Virtual Visit today.

- Easily scheduled appointments — flexible to YOUR schedule.
- Review hand-picked, board-certified providers and their profile.
- Accessible anywhere — at the office or from your home.
- Private and confidential.

WANT MORE INFORMATION?

Visit DoctorOnDemand.com, or contact Wellmark customer service at the phone number listed on the back of your ID card.

*Mental health coverage includes psychiatry services and medication management along with treatment for psychological conditions, emotional issues and chemical dependency. Please refer to your coverage manual for complete benefits information.

VIRTUAL VISITS CAN BE USEFUL WHEN YOU'RE DEALING WITH

- Depression
- Workplace Stress
- Relationship Issues
- Trauma & Loss
- Social or General Anxiety
- Addictions

Wellmark

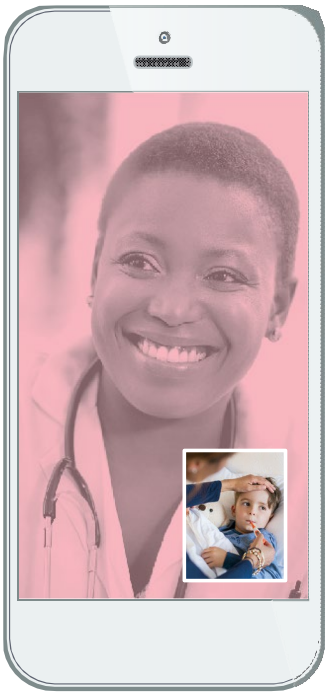
FEELING BETTER SHOULD BE EASY.

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.

2023 HEALTH PLAN COMPLIANCE NOTICES

Compliance Notices Include:

- CHIP Notice
- COBRA General Notice
- General FMLA Notice
- Genetic Information Nondiscrimination Act (GINA) Disclosures
- Health Insurance Exchange Notice (for companies who offer a health plan)
- Medicare Part D Creditable Coverage Notice
- Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure
- Michelle's Law Notice
- Newborns' and Mothers' Health Protection Act Notice
- No Surprise Billing
- Notice of Privacy Practices
- Special Enrollment Rights Notice
- Uniformed Services Employment and Reemployment Rights Act (USERRA) Notice
- WHCRA Notice

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your State for more information on eligibility –

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: https://dhs.iowa.gov/ime/members

Medicaid Phone: 1-800-338-8366

Hawki Website: http://dhs.iowa.gov/Hawki

Hawki Phone: 1-800-257-8563

HIPP Website:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp

HIPP Phone: 1-888-346-9562

Other States

ALABAMA – Medicaid
Website: http://myalhipp.com/ | Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ | Phone: 1-866-251-4861 | Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)

2023 HEALTH PLAN COMPLIANCE NOTICES

CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp | Phone: 916-445-8322 | Fax: 916-440-5676 | Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ | Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus | CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program | HIBI Customer Service: 1-855-692-6442

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

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

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ | Phone: 1-877-438-4479
All other Medicaid Website: https://www.in.gov/medicaid/ | Phone 1-800-457-4584

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884

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

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp | Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms | Phone: 1-800-442-6003 | TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms | Phone: -800-977-6740. | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: (617) 886-8102

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

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

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

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

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

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program | Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html | CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ | Phone: 1-844-854-4825

2023 HEALTH PLAN COMPLIANCE NOTICES

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx | http://www.oregonhealthcare.gov/index-es.html | Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/ | Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip | Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/ | Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select or https://www.coverva.org/en/hipp | Medicaid Phone: 1-800-432-5924 | CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ | Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002

WYOMING – Medicaid
Phone: 1-800-251-1269 | Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

US Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa

US Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

2023 HEALTH PLAN COMPLIANCE NOTICES

General Notice of COBRA Rights

(For use by single employer group health plans)

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 must pay for COBRA continuation coverage.

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

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

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 North Cedar Community Schools, 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;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to Kelly Stillwagon at 120 E North Street, Stanwood, IA 52337.

How is COBRA continuation coverage provided?

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

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

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

If you have questions

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

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator. Plan contact information for the 2023 plan year: Kelly Stillwagon at 120 E North Street, Stanwood, IA 52337.

2023 HEALTH PLAN COMPLIANCE NOTICES

General FMLA Notice

Employee Rights Under the Family & Medical Leave Act

The United States Department of Labor, Wage and Hour Division

Leave Entitlements

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Protections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint contact the U.S. Department of Labor | Wage and Hour Division at their website www.dol.gov/whd, 1-866-4-USWAGE (1-866-487-9243) or for TTY: 1-877-889-5627

Genetic Information Nondiscrimination Act (GINA) Disclosures

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Health Insurance Exchange Notice

(For Employers Who Offer a Health Plan to Some or All Employees)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: The Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Kelly Stillwagon at 120 E North Street, Stanwood, IA 52337.

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

2023 HEALTH PLAN COMPLIANCE NOTICES

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name North Cedar Community Schools	4. Employer Identification Number (EIN) 42-1430236	
5. Employer address 120 E North St	6. Employer phone number 563- 942-3341	
7. City Stanwood	8. State Iowa	9. ZIP code 52337
10. Who can we contact about employee health coverage at this job? Kelly Stillwagon		
11. Phone number 563- 942-3341	12. Email address	

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

- As your employer, we offer a health plan to:
  - ☑ All employees
- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are: covered to age 26

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

Note: Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

Medicare Part D Creditable Coverage Notice

Important Notice from North Cedar Community Schools About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with 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 Community Schools has determined that the prescription drug coverage offered by the 2023 plan year 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.

2023 HEALTH PLAN COMPLIANCE NOTICES

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 North Cedar Community Schools coverage will be affected. if you enroll in Medicare you and your dependents will not be able to come back to the employer paid coverage.

If you do decide to join a Medicare drug plan and drop your current North Cedar Community Schools coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with North Cedar Community Schools and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice or Your Current Prescription Drug Coverage
Contact the person listed below for further information call Cindy Gingerich at 319-668-1069. 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 North Cedar Community Schools changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Date:	4/12/2023
Name of Entity:	North Cedar Community Schools
Contact, Office:	Kelly Stillwagon
Address:	120 E North Street, Stanwood, IA 52337.
Phone Number:	563- 942-3341

Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the 2023 plan year with respect to mental health or substance use disorder benefits, please contact your plan administrator at 319-668-1069 x .

Michelle's Law Notice

Note: Pursuant to Michelle's Law, you are being provided with the following notice because the North Cedar Community Schools group health plan provides dependent coverage beyond age 26 and bases eligibility for such dependent coverage on student status. Please review the following information with respect to your dependent child's rights under the plan in the event student status is lost.

2023 HEALTH PLAN COMPLIANCE NOTICES

When a dependent child loses student status for purposes of North Cedar Community Schools group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the North Cedar Community Schools group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the North Cedar Community Schools group health plan, whichever is earlier.

In order to be eligible to continue coverage as a dependent during such leave of absence:

The North Cedar Community Schools group health plan must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary

To obtain additional information, please contact:
Kelly Stillwagon
120 E North Street
Stanwood, IA 52337.

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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, like a copayment, coinsurance, or deductible. You may have additional 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" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays 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 plan's deductible or 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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're 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 they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). 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.

https://www.cms.gov/nosurprises

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 can 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 types of 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.

2023 HEALTH PLAN COMPLIANCE NOTICES

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

if seen at an in network hospital, you may not be balanced billed by providers you seen during that time frame if they are not in network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "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 in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact the No Surprises Help Desk, operated by the U.S. Department of Health and Human Services, at 1-800-985-3059.

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Notice of Privacy Practices

North Cedar Community Schools
120 E North St
Stanwood , Iowa 52337
Privacy Official: Kelly Stillwagon
Effective Date: 04/12/2023

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

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

Your Choices

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

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

Our Uses and Disclosures

We may use and share your information as we:

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

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

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

2023 HEALTH PLAN COMPLIANCE NOTICES

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

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

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

You can complain if you feel we have violated your rights by contacting Kelly Stillwagon at 120 E North St, Stanwood , Iowa 52337

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

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

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

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

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

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:

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

Do research
We can use or share your information for health research.

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

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

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

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

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

Respond to lawsuits and legal actions

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

Our Responsibilities

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

For more information, see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

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

Notice of Special Enrollment Rights

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

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.

If you or your dependent(s) lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the loss of CHIP or Medicaid coverage.

If you or your dependent(s) become eligible to receive premium assistance under a state CHIP or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days of the determination of eligibility for premium assistance from state CHIP or Medicaid.

To request special enrollment or obtain more information, contact Kelly Stillwagon at 120 E North Street, Stanwood, IA 52337.

2023 HEALTH PLAN COMPLIANCE NOTICES

USERRA Notice

Your Rights Under USERRA

A. The Uniformed Services Employment and Reemployment Rights Act

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

B. Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

C. Right to Be Free from Discrimination and Retaliation if you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service; then an employer may not deny you initial employment; reemployment; retention in employment; promotion; or any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

D. Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

E. Enforcement

- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at *http://www.dol.gov/vets.* An interactive online USERRA Advisor can be viewed at *http://www.dol.gov/elaws/userra.htm*.

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS and may be viewed on at: *http://www.dol.gov/vets/programs/userra/poster.htm*. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees. U.S. Department of Labor, Veterans' Employment and Training Service, 1-866-487-2365.

Women's Health and Cancer Rights Act (WHCRA) Notices

Enrollment Notice: If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications of the mastectomy, including lymphedema. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: $1000 deductible (in-network) and 20% coinsurance (in-network) and $2000 deductible (out-of-network) and 40% coinsurance (out-of-network). If you would like more information on WHCRA benefits, call your plan administrator at 319-668-1069.

Annual Notice: Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 319-668-1069 for more information

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.