North Cedar
Community School District

Employee Benefit Guide

Effective 07/01/2025 to 06/30/2026

Eligibility & Ease Enrollment

ELIGIBILITY

If you're a full-time employee, you're eligible to enroll in the benefits outlined in this guide once you have completed your new hire probation period for benefits.

- Full-time employees are those who work 30 or more hours per week.
- The new hire probation period for benefits ends on the first day of the month following your date of hire.

In addition, the following family members are eligible for medical, dental and vision coverage:

- Spouse
- Children under the age of 26

ENROLLMENT

- **Our Annual Open Enrollment Period begins May 15th and closes on May 23rd, 2025**
- **The benefits you choose during this open enrollment period will become effective on July 1, 2025.**

Complete your Ease Online Enrollment

Once you have reviewed your guide you will need to log into the EASE Online Enrollment Platform to begin your benefit selections. We have included instructions for using Ease on the next page.

Remember, your online enrollment must be completed by 5pm on May 23rd or your to be considered enrolled in benefits. If you miss open enrollment, your next opportunity will be during the 2026 open enrollment period unless you have a qualifying event as defined by the IRS.

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. Contact your plan administrator should you have any questions regarding the benefits you are being offered.

How to Make Changes After Open Enrollment

Unless you experience a life-changing qualifying event, as defined by the IRS, 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 employment status or a change in coverage under another employer-sponsored plan
- Select change in residence situations (HMO)

ease

On-line Enrollment

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.

Health & Pharmacy

	HDHP Plan 1	HDHP Plan 2	Health Savings Account Plan 3
Network	Alliance Select*	Wellmark Blue HMO**	Wellmark HMO
Actual Plan Design			
Annual Deductible	$8,000 Single $16,000 Family	$8,000 Single $16,000 Family	$8,000 Single $16,000 Family
Coinsurance You Pay	0%	0%	0%
Out-of-Pocket Maximum	$8,000 Single $16,000 Family	$8,000 Single $16,000 Family	$8,000 Single $16,000 Family
North Cedar Reimbursement Plan via Difference Card	Difference Card Pays	Difference Card Pays	Member pays the first
	$4,000`Single	$4,000 Single	$5,500 Single
	$8,000 Family	$8,000 Family	$11,000 Family
	Member's potential cost	Member's potential cost	Difference Card pays after
	$4,000 Single	$4,000 Single	$2,500 Single
	$8,000 Family	$8,000 Family	$5,000 Family
Common Services			
Preventive	Covered at 100%	Covered at 100%	Covered at 100%
Primary Care Physician	Applies to Deductible	Applies to Deductible	Applies to Deductible
Specialist	Applies to Deductible	Applies to Deductible	Applies to Deductible
Urgent Care	Applies to Deductible	Applies to Deductible	Applies to Deductible
Emergency Room	Applies to Deductible	Applies to Deductible	Applies to Deductible
All Pharmacy costs	Applies to Deductible	Applies to Deductible	Applies to Deductible
Employee Monthly Premium			
Employee only	$180.52	$104.80	$0.00
Employee + Spouse	$1,139.57	$984.13	$772.37
Employee + Child(ren)	$997.72	$757.61	$658.14
Family	$2,073.94	$1,840.81	$1,524.85

*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

The Difference Card

WELCOME TO YOUR DIFFERENCE CARD BENEFITS!

The Difference Card is a benefit funded by your employer that helps you save money on your medical costs.

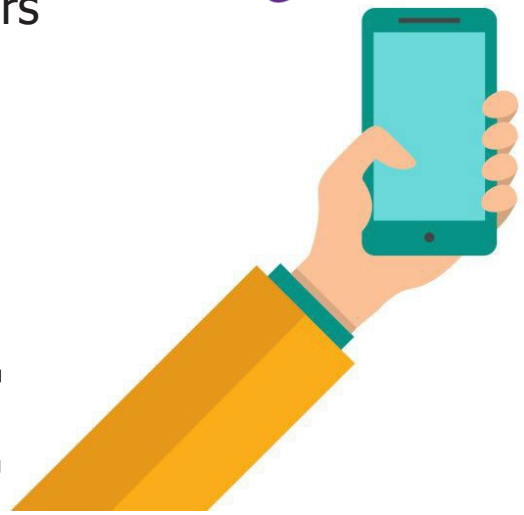
GETTING STARTED

MOBILE APP

Using your smart phone's camera, scan this to download mobile app.

With The Difference Card Smart Mobile App, you can:

- Snap a picture to easily submit your claim
- Find the cheapest place to buy your prescriptions
- Compare cost and search for providers
- View your account balance
- Check claim status
- Sign up for Direct Deposit

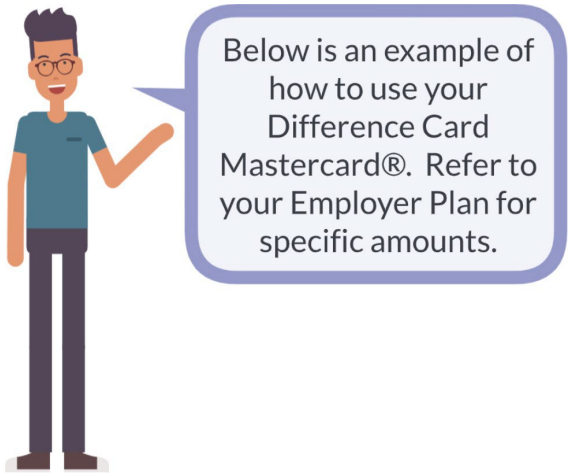


LEARN MORE

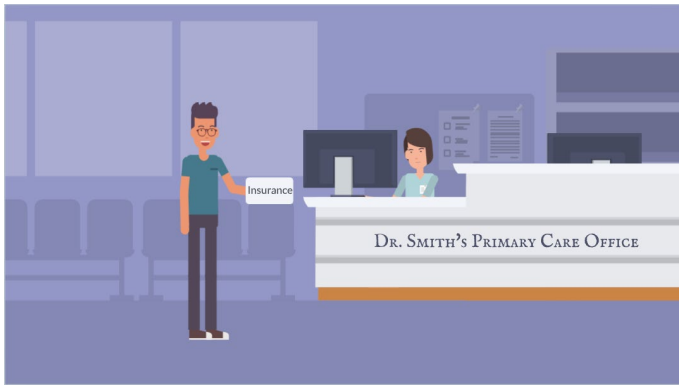
Visit us online at DifferenceCard.com .

Questions? Our Customer Care Team is available Monday - Friday, from 8AM to 11PM ET.

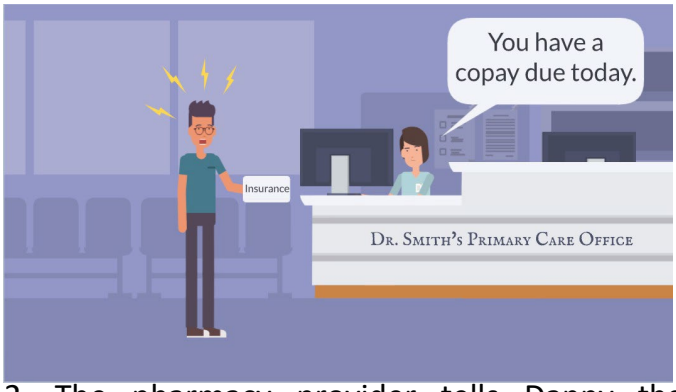
Call us at (888) 343-2110



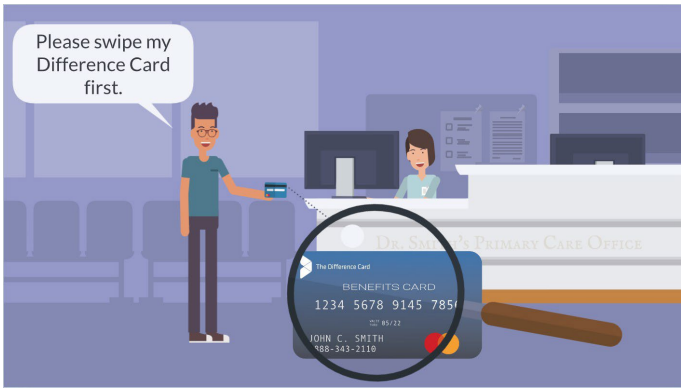
HOW TO SWIPE YOUR DIFFERENCE CARD



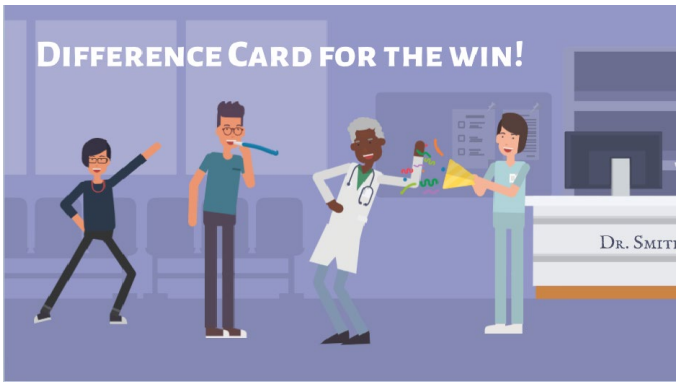
1. When visiting his doctor or a pharmacy, Danny gives them his Insurance Card first.



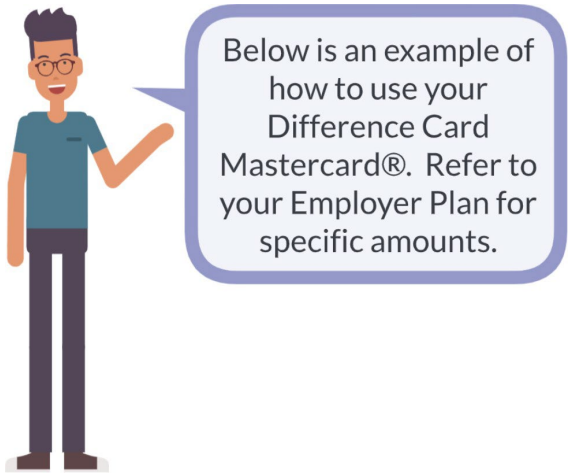
2. The pharmacy provider tells Danny the amount due for his costs. Danny's medical provider's should bill him for the services received.



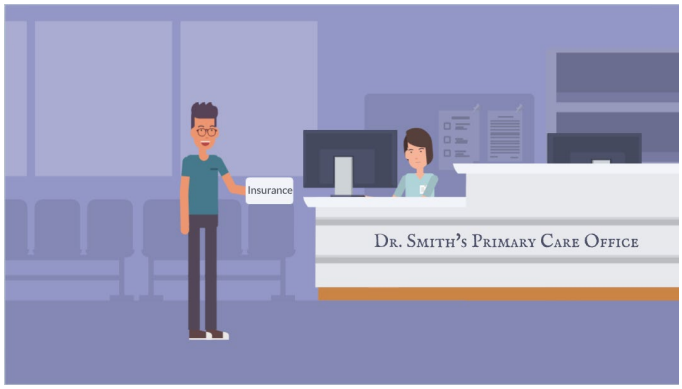
3. For prescriptions Danny can swipe his Difference Card for the full cost.
For medical services, once charged, Danny may use his Difference Card for payment.



4. The amount requested is now satisfied using The Difference Card. It's that easy!

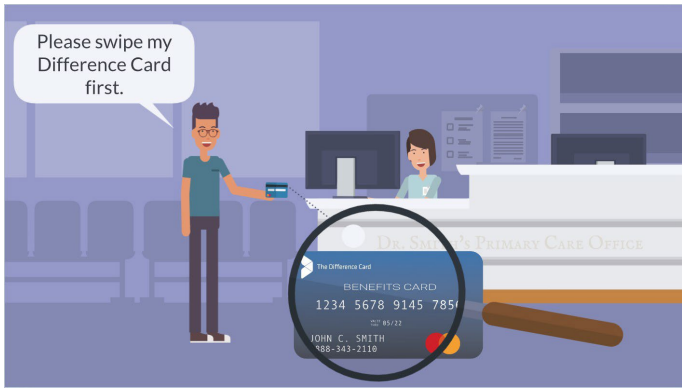


HOW TO SWIPE YOUR DIFFERENCE CARD

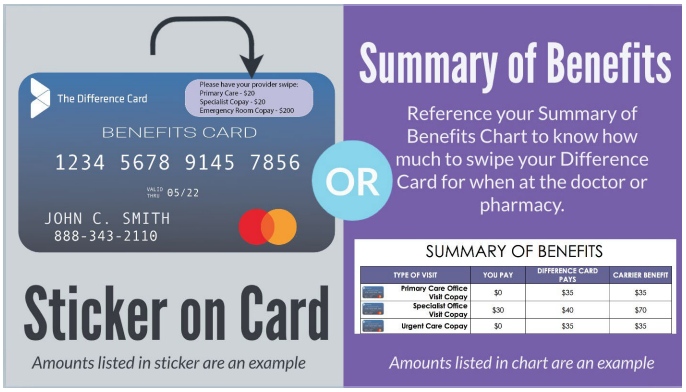


1. When visiting his doctor or a pharmacy, Danny gives them his Insurance Card first.

2. The provider tells Danny the amount due for the service.

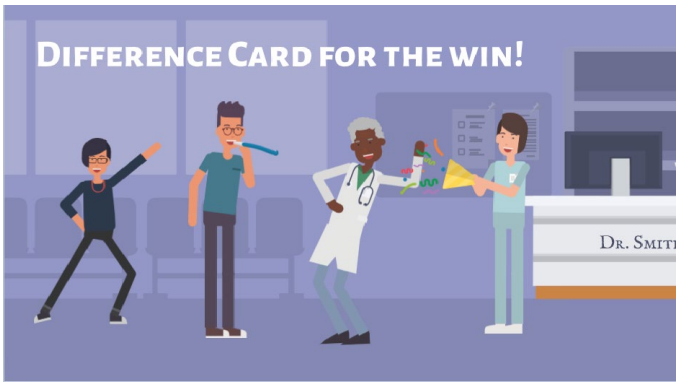


3. Danny first uses his Difference Card funded by his employer to lower his out-of-pocket cost.



4. He tells the provider the amount to swipe for by referring to a sticker on his card or the amount listed in his Summary of Benefits.

5. Danny pays the remaining amount with his personal card or cash. *If you have an FSA, you can swipe The Difference Card once and it will pull the funds appropriately.

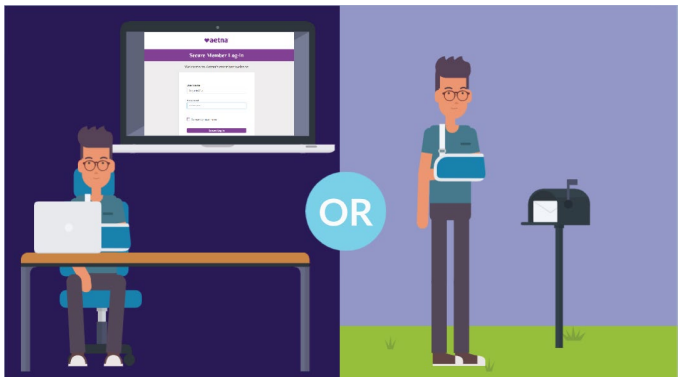


6. The total amount requested is now satisfied using The Difference Card and Danny's personal funds. It's that easy!

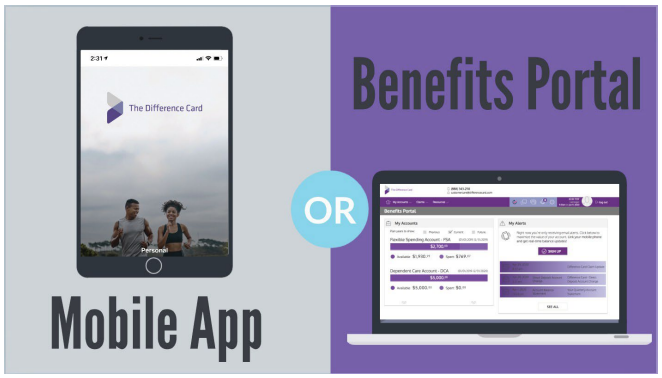
HOW TO GET HELP WITH YOUR MEDICAL BILLS

1. When Danny goes to the doctor, he does not pay for some services up front like major medical services.

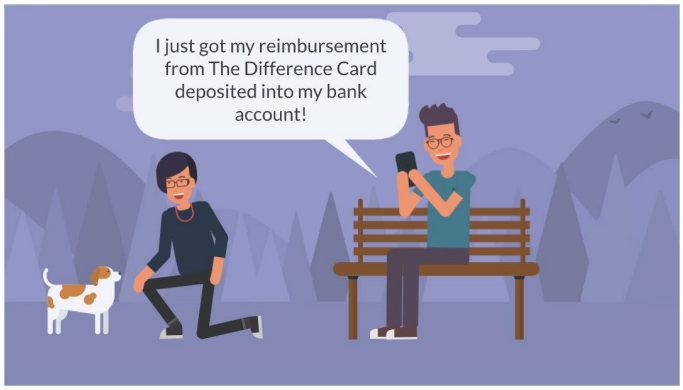
2. Instead, he will present his Insurance Card to the medical provider and will get a bill and an insurance statement* later.



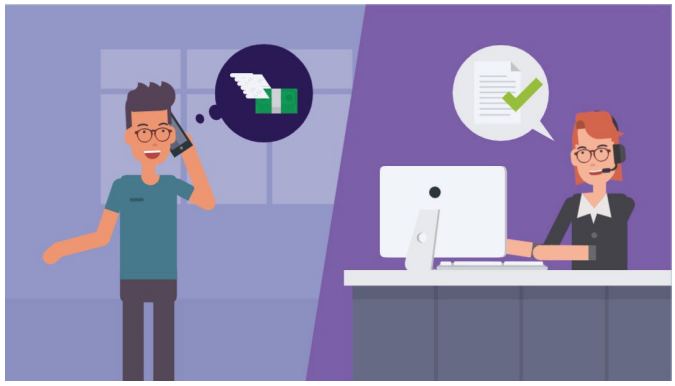
3. Danny will get his insurance statement* either through the Insurance Provider's website or in the mail.



4. Danny then logs into his account online or through the mobile app to upload his insurance statement* to submit his claim.



5. Claims on average are processed in 2 business days. If Danny's claim is eligible for reimbursement, his funds will be direct deposited or mailed to his home.



6. Danny compares the medical bill to the insurance statement and pays the amount he owes. *Danny may have to pay a portion out of pocket before he is eligible for reimbursement.

*An Insurance Statement, sometimes called an Explanation of Benefits (EOB), describes what costs your Insurance Provider will cover for medical care.

WAYS TO SUBMIT YOUR CLAIM

MOBILE

Download the Difference Card Smart Mobile App to submit your claim with a picture.

ONLINE

Login to your account at DifferenceCard.com to submit your claim online.

MAIL

Fill out a Reimbursement Form and submit your documents via mail.

FAX

Fill out a Reimbursement Form and submit your documents via fax.

DIRECT DEPOSIT

The fastest way to get your money.

Money will come back to you via direct deposit if you select that as your Reimbursement Preference.

TOOLS ON THE GO

Scan this code with your camera app to get helpful resources at your fingertips.

SCAN ME

The Difference Card

SUMMARY OF BENEFITS

North Cedar School | **WELLMARK PLAN 1 PPO** | **7/1/2025** to **6/30/2026**

Swipe card for benefit listed under the "Difference Card Pays" column.

TYPE OF VISIT	YOU PAY	DIFFERENCE CARD PAYS	WELLMARK BENEFIT
PHYSICIAN SERVICES			
Primary Care Office Visit Copay	Deductible after DC Funding	First $4,000/$8,000	Deductible
Specialist Office Visit Copay	Deductible after DC Funding	First $4,000/$8,000	Deductible
Preventive Care / Screening / Immunization	No Charge		
Urgent Care	Deductible after DC Funding	First $4,000/$8,000	Deductible
PHARMACY			
Prescription Deductible Application	Integrated with Medical Deductible		
Prescription Individual Deductible			
Prescription Family Deductible			
Retail Prescriptions			
Mail Order Prescriptions			
DIAGNOSTIC PROCEDURES			
Diagnostic Test- Lab Bloodwork	Deductible after DC Funding	First $4,000/$8,000	Deductible
Diagnostic Test X-Ray	Deductible after DC Funding	First $4,000/$8,000	Deductible
Complex Imaging (CT/Pet Scans, MRIs)	Deductible after DC Funding	First $4,000/$8,000	Deductible
HOSPITAL SERVICES			
Emergency Room Care	Deductible after DC Funding	First $4,000/$8,000	Deductible
Outpatient Surgery	Deductible after DC Funding	First $4,000/$8,000	Deductible
Inpatient Hospital	Deductible after DC Funding	First $4,000/$8,000	Deductible
IN NETWORK DEDUCTIBLE & COINSURANCE			
Qualified High Deductible Health Plan	No		
Deductible Accumulation Period	Calendar year		
Family Deductible Accumulation Type	Family Total Accumulation		
In-Network Individual Deductible	Last $4,000	First $4,000	$8,000
In-Network Family Deductible	Last $8,000	First $8,000	$16,000

In-Network Family Multiplier 2

Mail Order Multiplier 2

All claims must be submitted within 3 months of the end of the deductible accumulation period.

Terminated members must submit claims within 3 months of the termination date.

All Out-of-Network Services are subject to the Deductible.

Information on this document based on carrier SBC.

Please have your provider swipe the Difference Card for the following amounts:

In-Network Medical & Pharmacy Swipe - First $4,000/$8,000

Call 888.343.2110 with any questions.

Download the Mobile App to View and Submit Claims

SCAN THIS WITH YOUR CAMERA

The Difference Card

SUMMARY OF BENEFITS

North Cedar School | **WELLMARK PLAN 2 HMO** | **7/1/2025** to **6/30/2026**

Swipe card for benefit listed under the "Difference Card Pays" column.

TYPE OF VISIT	YOU PAY	DIFFERENCE CARD PAYS	WELLMARK BENEFIT
PHYSICIAN SERVICES			
Primary Care Office Visit Copay	Deductible after DC Funding	First $4,000/$8,000	Deductible
Specialist Office Visit Copay	Deductible after DC Funding	First $4,000/$8,000	Deductible
Preventive Care / Screening / Immunization	No Charge		
Urgent Care	Deductible after DC Funding	First $4,000/$8,000	Deductible
PHARMACY			
Prescription Deductible Application	Integrated with Medical Deductible		
Prescription Individual Deductible			
Prescription Family Deductible			
Retail Prescriptions			
Mail Order Prescriptions			
DIAGNOSTIC PROCEDURES			
Diagnostic Test- Lab Bloodwork	Deductible after DC Funding	First $4,000/$8,000	Deductible
Diagnostic Test X-Ray	Deductible after DC Funding	First $4,000/$8,000	Deductible
Complex Imaging (CT/Pet Scans, MRIs)	Deductible after DC Funding	First $4,000/$8,000	Deductible
HOSPITAL SERVICES			
Emergency Room Care	Deductible after DC Funding	First $4,000/$8,000	Deductible
Outpatient Surgery	Deductible after DC Funding	First $4,000/$8,000	Deductible
Inpatient Hospital	Deductible after DC Funding	First $4,000/$8,000	Deductible
IN NETWORK DEDUCTIBLE & COINSURANCE			
Qualified High Deductible Health Plan	No		
Deductible Accumulation Period	Calendar year		
Family Deductible Accumulation Type	Family Total Accumulation		
In-Network Individual Deductible	Last $4,000	First $4,000	$8,000
In-Network Family Deductible	Last $8,000	First $8,000	$16,000

In-Network Family Multiplier 2

Mail Order Multiplier

All claims must be submitted within 3 months of the end of the deductible accumulation period.

Terminated members must submit claims within 3 months of the termination date.

Information on this document based on carrier SBC.

Please have your provider swipe the Difference Card for the following amounts:

In-Network Medical
&
Pharmacy Swipe - First $4,000/$8,000

Call 888.343.2110 with any questions.

SCAN THIS WITH YOUR CAMERA

Download the Mobile App to View and Submit Claims

SUMMARY OF BENEFITS

The Difference Card

North Cedar School | **WELLMARK PLAN 3 HSA HMO** | **7/1/2025 to 6/30/2026**

Swipe card for benefit listed under the "Difference Card Pays" column.

Submit a claim for reimbursement with EOB for payment.

TYPE OF VISIT	YOU PAY	DIFFERENCE CARD PAYS	WELLMARK BENEFIT
PHYSICIAN SERVICES			
Primary Care Office Visit Copay	Deductible	Remaining Deductible	Deductible
Specialist Office Visit Copay	Deductible	Remaining Deductible	Deductible
Preventive Care / Screening / Immunization	No Charge		
Urgent Care	Deductible	Remaining Deductible	Deductible
PHARMACY			
Prescription Deductible Application	Integrated with Medical Deductible		
Prescription Individual Deductible			
Prescription Family Deductible			
Retail Prescriptions			
Mail Order Prescriptions			
DIAGNOSTIC PROCEDURES			
Diagnostic Test- Lab Bloodwork	Deductible	Remaining Deductible	Deductible
Diagnostic Test X-Ray	Deductible	Remaining Deductible	Deductible
Complex Imaging (CT/Pet Scans, MRIs)	Deductible	Remaining Deductible	Deductible
HOSPITAL SERVICES			
Emergency Room Care	Deductible	Remaining Deductible	Deductible
Outpatient Surgery	Deductible	Remaining Deductible	Deductible
Inpatient Hospital	Deductible	Remaining Deductible	Deductible
IN NETWORK DEDUCTIBLE & COINSURANCE			
Qualified High Deductible Health Plan	Yes		
Deductible Accumulation Period	Calendar year		
Family Deductible Accumulation Type	Family Total Accumulation		
In-Network Individual Deductible	First $5,500	Last $2,500	$8,000
In-Network Family Deductible	First $11,000	Last $5,000	$16,000

In-Network Family Multiplier 2

Mail Order Multiplier 2

All claims must be submitted within 3 months of the end of the deductible accumulation period.
Terminated members must submit claims within 3 months of the termination date.

Information on this document based on carrier SBC.

Please have your provider swipe the Difference Card for the following amounts:

Pharmacy - Last $2,500/$5,000

Call 888.343.2110 with any questions.

Download the Mobile App to View and Submit Claims

SCAN THIS WITH YOUR CAMERA

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 (aka 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.

Wellmark Health Plan of Iowa

Wellmark Health Plan Highlights

Making the most of your Wellmark Benefits.

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

Learning about health insurance: Knowing a basic glossary of insurance terms like deductible, coinsurance and copay helps you understand your coverage better and eliminate future frustration.

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

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

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

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

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

This guide is not your official plan document, which provides specific details about covered and non-covered services. That information can be found in one or more of the three ways below.

How to view your official plan documents

1. Log in to myWellmark at myWellmark.com and click on the My Plans tab.
2. Go to SBCCMFinder.Wellmark.com/Search. You can find the Product ID number on your benefit summary page.
3. Or reach out to your employer to obtain your official plan document.

Register at myWellmark.

If you are not already registered with myWellmark, sign up for your free account by visiting myWellmark at https://www.wellmark.com/mywellmark. Once there, click the blue “Register Now” button and follow the prompts.

Use myWellmark, our secure online member portal, to:

- Find information related to your specific benefits
- Estimate the cost of care for the most common procedures and services
- 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
- Find an in-network doctor or provider and select your primary care provider (PCP)
- Get insights to manage your well-being

Knowing your network saves you money.

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

Network advantages for you

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

- Lower out-of-pocket costs.
- Referrals aren’t required by Wellmark, so you can easily see specialists.
- Waived deductibles for eligible office visits (unless you have a high-deductible health plan).
- Your out-of-pocket costs apply toward your deductible or out-of-pocket maximum.
- In-network providers handle claim filing and obtaining insurance approval tasks for you.

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

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

Discover the simplest way to keep your costs down.

Visit https://www.wellmark.com/blue/plan-smart/the-simplest-way-to-keep-your-costs-down

Wellmark Health Plan of Iowa

What to know about your HMO.

Your network is the Wellmark Health Plan of Iowa network. This network gives you access to 100 percent of hospitals and 98 percent of doctors in Iowa[1] and features lower cost-share benefits when visiting your primary care provider (PCP).

Better health outcomes, less hassle with a designated PCP

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

- Establishing a long-term relationship with a single health care provider who knows or will get to know you, your health and your health history.
- Managing your health care needs and maintaining your medical records.
- Assisting with a wide range of medical conditions and committing to improving your health.
- Connecting you to other in-network providers.
- Primary care services provided by your designated PCP are the lowest out-of-pocket cost.

In or out of network, you're always covered in the case of an emergency. However, you can avoid higher out-of-pocket costs by visiting your designated PCP for minor, non-emergency situations. Preventive services are $0 out-of-pocket cost when received from any in-network provider.

[1] Wellmark Blue Cross and Blue Shield network numbers as of May 2020.
[2] Blue Cross Blue Shield, The Health of America Report®

How to find, select or change your designated PCP

- Simply log in to **mywellmark.com** to search for and select a PCP from our list of in-network general/family practice physicians, internists, nurse practitioners, physician assistants, geriatricians, or pediatricians.
- Need to make a change? You can update your PCP designation at any time on **mywellmark.com**.

Find the best in-network providers

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

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

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

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

Get coverage out-of-state with Guest Memberships

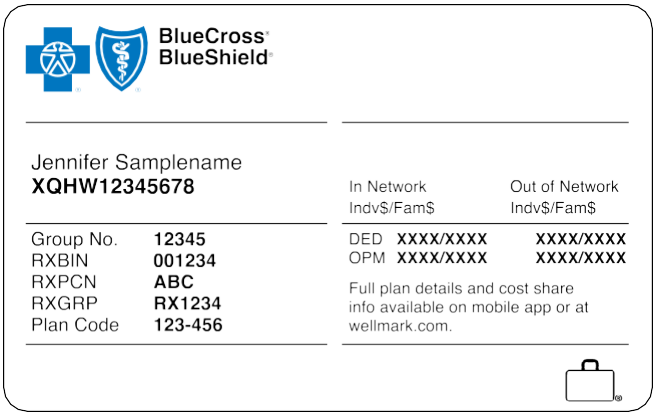
Guest Memberships allow you and your covered dependents to receive services from participating Blue Cross and Blue Shield hospitals and health care providers when traveling or residing outside Iowa, but still within the United States, for at least 90 consecutive days.

Guest Memberships are a valuable benefit for:

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

How to request and use your Guest Membership:

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



FRONT

BACK

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

Show your Wellmark ID card in and out of Iowa

Your ID card is the link to emergency care when you're away from home. To be eligible for benefits, show your ID card to any Blue Plan participating hospital or provider.

Showing your ID card helps ensure providers bill you appropriately.

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

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

Wellmark Health Plan of Iowa

What to know about your PPO.

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

Coverage across the United States

With the BlueCard program, you only pay the provider the usual out-of-pocket expenses (non-covered services, deductible, copay or coinsurance) when you use participating BlueCard providers across the country. Preventive services are $0 out-of-pocket cost when received from any in-network provider.

Coverage across the world

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

How to receive coverage outside the United States:

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

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

Before you see a provider, consider selecting a personal doctor, also known as a primary care provider. Your PCP can play a major role in helping you manage and coordinate your health care needs. Advantages include: Participating providers agree to accept payment arrangements of the Blue Plan in their home state, which may result in a savings to you.

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

Managing your health care needs and maintaining your medical records.

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

Referring you to another in-network provider.

Find the best in-network providers.

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

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

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

Looking for the best in specialty care?

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

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

Your ID card is the link to emergency care when you're away from home. To be eligible for benefits, show your ID card to any Blue Plan participating hospital or provider.

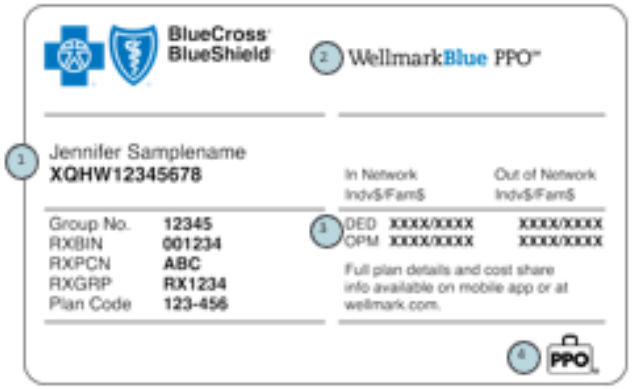
Show your Wellmark ID card at home and abroad

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

1. Every contract holder has an identification number. It starts with a three-character prefix that identifies your Blue Cross and Blue Shield plan and is followed by your personal identification number.
2. The name of your health plan appears here.
3. The amount of your deductible and/or out-of-pocket maximum.
4. This logo identifies you as a BlueCard PPO® member.

The back of your ID card includes information to:

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



FRONT

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Virtual visits offer you fast, convenient and safe care

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

Why see a doctor online?

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

Don't wait for illness to strike, visit **DoctorOnDemand.com** to register, or your app store and download the app for free!

Visit Doctor On Demand and get prescriptions[2] for

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

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

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

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

Get the most out of your pharmacy benefits!

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

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

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

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

You'll want to double check the Wellmark Drug List if you get a new prescription or switch medications.

Top Three Ways to Save on Prescription Drugs.

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

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

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

How to enroll in mail order pharmacy service

1. Ask your provider to write two prescriptions, one for an initial short-term supply (e.g., 30-days) you can fill immediately at a participating retail pharmacy and a second for the maximum days' supply allowed by your plan, plus refills.
2. Register with the mail order pharmacy in one of three ways:
   - Online at **Wellmark.com/forms**, where you'll also find the forms you need to enroll by phone or fax.
   - Mail: Complete a Registration and Prescription Order form and submit it with your first prescription order.
   - Phone: Call the mail order pharmacy at 866-611-5961 Hours are Mon–Fri., 7 a.m.–9 p.m. CT, Sat. 7 a.m.–4 p.m. CT.
3. Refill prescriptions by mail, phone or online once you've registered.

Wellmark Health Plan of Iowa

Specialty drugs and pharmacies

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

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

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

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

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

How to order specialty drugs

1. Call SVS Specialty Pharmacy at 800-237-2767 Monday-Friday, 6:30am – 8:00pm CT
2. Provide your provider's contact information and your Wellmark ID card information.
3. A representative will confirm the prescription and dosage with your doctor and make arrangements to get your order delivered.
4. Your provider will work on your behalf to start your specialty drug therapy.
5. Find additional instructions and enrollment forms at Wellmark.com/forms.

Get free prescription drug tools

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

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

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 access to your favorite myWellmark tools on your smartphone. Get the speed and convenience of:

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

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

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

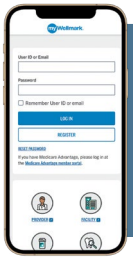
- The amount your provider charged for each service
- How much your health plan paid for each service
- The amount you saved by staying in-network
- Any out-of-pocket costs that the provider will bill you for separately

How to read your EOB and get it online

Confused about your EOB? Learn more at: **Wellmark.com/EOB**.

You can also go paperless and get your EOBs delivered to you immediately in four easy steps.

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



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.

Wellmark Health Plan of Iowa

Case Management Services.

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

You get:

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

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

Three ways to engage in Wellmark's case management program:

1. You may consider taking advantage of Case Management by calling BeWell 24/7 — 844-84-BEWELL (844-842-3935) —to speak with a nurse, discuss your health concern and help determine if Case Management is right for you.
2. You may be identified through your claims and contacted by Wellmark via mail or phone.
3. Your doctor may refer you to the program and then you'll be contacted via mail or phone.

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.

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.

Transition of care. Wellmark's nurses will contact you for pre and post-discharge follow-up for select hospital admissions to provide education, resources and support. The purpose of these calls is to make sure you are on the path to recovery and have not experienced any new symptoms.

Case management. For severe, complex and chronic conditions (for example, strokes, brain injuries, complications from diabetes and others), Wellmark provides additional nurse coaching and support. We want to help coordinate care for

you and overcome barriers you may be facing during your recovery. We will talk through in-home care, meal delivery or other support.

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.

Pregnancy Support. Wellmark offers guidance and support to women throughout their pregnancy and postpartum.

Wellmark Health Plan of Iowa

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:

- **Access to nurses —** Rather receive support throughout your pregnancy over the phone? You can request a call from a Case Management Pregnancy Support nurse by calling 800-552-3993 ext. 3727.
- **BEWELL 24/7℠—** Call 844-84-BEWELL to connect with a real person who can answer your most pressing questions. We'll take the time to listen to and address all your concerns.
- **Online pregnancy assessment —** Wellmark offers both prenatal and postpartum assessments. Go to myWellmark and enter your health history and information to see if you may benefit from nurse support over the phone.
- **WebMD® pregnancy assistant —** Find answers to your pregnancy and postpartum-related questions from reputable health care professionals who you can trust.
- **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.

The Wellmark Wellness Center can help you reach your health goals

The Wellmark Wellness Center powered by WebMD® offers:

- Wellness Assessments that give you accurate, confidential and personalized reports that summarize what you are doing well and create personalized action steps to help you improve different areas of your health and well-being.
- Personalized experiences with articles and resources that are tailored to your personal interests and health status.
- Well-being resources including podcasts, interactive quizzes and calculators, videos, a symptom checker and more.
- The ability to sync your Fitbit® activity tracker and monitor your calories burned, exercise minutes and daily steps.
- Daily Habits provide a range of suggested activities that help you progress toward your individual goals based upon information you supply regarding your health, personal interests and current habits.

Get started today

Log in or register for **myWellmark®** at **myWellmark.com** or via the Wellmark mobile app.

Once you're logged in, click the **Well-being** tab and then the **Visit Wellness Center** button. Then, take your Wellness Assessment to determine your health goals and make an action plan on how you can reach them.

Get the most out of your health insurance by taking care of yourself

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

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

- **Physical —** When you feel better physically, you're happier, healthier and spend less time and money at the doctor's office.
- **Career —** It's important to your health to be able to use your strengths at work and understand how what you do ties to your organization's business goals.
- **Financial —** Nearly 78 percent of Americans are living paycheck-to-paycheck. Look into programs to help you trim debt or save money, they can help ease your mind.
- **Social —** Relationships between friends, family and coworkers can help define who you are and how you feel. So make the time to improve your social well-being for better health.
- **Community —** 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.
- **Emotional —** Being emotionally grounded is essential to leading a happy and productive life. Get the resources and support you need to improve your emotional and mental health.

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

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.

Wellmark Health Plan of Iowa

Take advantage of all of the resources available to you as a Wellmark member.

BeWell 24/7: With BeWell 24/7 you have access to health advocacy, nurse support and care navigation from real people 24/7 at 844-842-3935. Use this feature to get answers to health questions, locate in-network doctors, know the best place to go for care, find guidance for complex health issues, and to get decision making support.

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

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

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

myWellmark.com: Your personal health care information is at your fingertips with myWellmark — no matter your location — with tools, resources and insights to help you manage health care spending and live a healthier life. This includes the Wellmark Wellness Center, where you can learn more about your personal health and use tools to help you maintain or improve it!

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

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

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

Wellmark.com/glossary: This covers basic insurance terms like deductible, coinsurance and copay to help you understand your coverage better and alleviate frustration in the future.

Wellmark Drug List: This gives the drug name, category, tier and what special authorization is required for all the prescription drugs so you can make sure your plan covers whatever drug your doctor prescribes.

Enrolling in a High Deductible Health Plan (HDHP)?

Know your benefits, and how an HSA helps you pay for care now and in the future.

A Health Savings Account (HSA) provides a valuable savings component that can either be used to pay for out-of-pocket costs tax-free or to save money for the future. Here are some advantages of an HSA:

- **Lower premiums—**This means there is more cash to invest in the HSA and to eventually put toward the deductible (as opposed to higher monthly premiums associated with traditional health plans).
- **Portability—**If your employment situation changes, you keep the HSA and have the benefit of past investments.
- **Employer contributions—** also contributes to your HSA each year, boosting your ability to save.
- **Tax-free savings with tax-free interest—**HSAs provide tax-free funds to pay medical bills, and funds also accumulate tax-free to save for the future. The best part is, once you turn 65 and are eligible for Medicare, you can use those funds for anything without a penalty, making it a valuable retirement savings tool. In fact, HSAs offer more favorable terms than IRAs in terms of saving for retirement health needs.
- **The catch-up contribution—**In addition to the annual limit for HSA contributions, people aged 55 and older can contribute an extra $1,000 per year.

It is also important to be aware of potential drawbacks. If you have many out-of-pocket medical expenses, you may struggle to use your HSA for retirement savings since you will be using the funds for your current bills. In addition, the desire to take advantage of the HSA as a savings tool may lead some individuals to forgo medical care or prescription drugs that they need. This is never a good idea, as it can lead to more expensive and serious medical complications down the road.

If you are considering an HSA, examine the benefits and potential risks and be sure to discuss with your family. Contact HR if you have more questions about our HSA offering.

HSA Limits

The following chart shows the health savings account (HSA) limits that will apply for 2025, along with the 2024 limits for comparison purposes. The IRS limits for HSA contributions, as well as the minimum deductible and out-of-pocket maximum limits for high deductible health plans (HDHPs), will increase in 2025.

Type of Limit		2024	2025	Change
HSA Contribution Limit	***Self-only***	$4,150	$4,300	**Up $150**
	Family	$8,300	$8,550	**Up $250**
HSA Catch-up Contributions *(not subject to adjustment for inflation)*	***Age 55 or older***	$1,000	$1,000	No change
HDHP Minimum Deductible	***Self-only***	$1,600	$1,650	**Up $50**
	Family	$3,200	$3,300	**Up $100**
HDHP Maximum Out-of-Pocket Expense Limit *(deductibles, copayments and other amounts, but not premiums)*	***Self-only***	$8,050	$8,300	**Up $250**
	Family	$16,100	$16,600	**Up $500**

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. ✓ 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 future 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 cannot 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.

HSA Examples of Eligible Expenses

Your health savings account (HSA) may reimburse:

- Qualified medical expenses incurred by the account beneficiary and his or her spouse and dependents;
- COBRA premiums;
- Health insurance premiums while receiving unemployment benefits;
- Qualified long-term care premiums*; and
- Any health insurance premiums paid, other than for a Medicare supplemental policy, by individuals age 65 or older; and
- Certain personal protective equipment (PPE)—such as masks, hand sanitizer and sanitizing wipes—used for the primary purpose of preventing the spread of COVID-19.

Distributions made from an HSA to reimburse the account beneficiary for eligible expenses are excluded from gross income.

Qualified Medical Expenses

The Internal Revenue Service (IRS) defines qualified medical care expenses as amounts paid for the diagnosis, cure or treatment of a disease, and for treatments affecting any part or function of the body. The expenses must be primarily to alleviate a physical or mental defect or illness.

The products and services listed below are examples of medical expenses eligible for payment under your HSA, when such services are not covered by your high-deductible health plan. To be an expense for medical care, the expense has to be primarily for the prevention or alleviation of a physical or mental defect or illness.

This list is not all-inclusive; additional expenses may qualify, and the items listed below are subject to change in accordance with IRS regulations. For more information or clarification on individual list items, refer to Publication 502 or consult a tax professional.

- Abortion
- Acupuncture
- Alcoholism
- Ambulance
- Annual physical examination
- Artificial limb
- Artificial teeth
- Bandages
- Birth control pills
- Body scan
- Braille books and magazines
- Breast pumps and supplies
- Breast reconstruction surgery
- Capital expenses
- Car
- Chiropractor
- Christian Science practitioner
- Contact lenses
- Crutches
- Dental treatment
- Diagnostic devices
- Disabled dependent care expenses
- Drug addiction
- Drugs
- Eye exam
- Eyeglasses
- Eye surgery
- Fertility enhancement
- Founder's fee
- Guide dog or other service animal
- Health institute
- Health maintenance organization (HMO)
- Hearing aids
- Home care
- Home improvements
- Hospital services
- Insurance premiums
- Laboratory fees
- Lactation expenses
- Lead-based paint removal
- Learning disability
- Legal fees
- Lifetime care—advance payments
- Lodging
- Long-term care
- Meals
- Medical conferences
- Medical information plan
- Medicines
- Nursing home
- Nursing services
- Operations
- Optometrist
- Organ donors
- Osteopath
- Oxygen
- PPE used for the primary purpose of preventing the spread of COVID-19, such as:
  - Masks
  - Hand sanitizer
  - Sanitizing wipes
- Physical examination
- Pregnancy test kit
- Premium tax credit
- Prescribed weight-loss programs
- Prescription drugs
- Prosthesis
- Psychiatric care
- Psychoanalysis
- Psychologist
- Special education
- Special home for intellectually and developmentally disabled
- Sterilization
- Stop-smoking programs
- Surgery
- Telephone
- Television
- Therapy
- Transplants
- Transportation
- Trips
- Tuition
- Vasectomy
- Vision correction surgery
- Wheelchair
- Wig
- X-ray

Source: www.irs.gov

Plans that do not allow reimbursement of all eligible medical expenses as defined by the IRS and Department of Treasury must customize this article prior to use.

** For purposes of reimbursement of qualified long-term care premiums from an HSA, reimbursement in excess of the amount which may be deducted on an individual's personal tax return is not an eligible expense. IRS 213(d)(10) establishes the tax deduction allowed for qualified long-term care premiums on individual tax returns. If the HSA reimburses long-terms care premiums for an amount greater than set forth in IRC 213(d)(10), the amount greater than allowed is included in the account holder's taxable income and is subject to a 20 percent penalty.*

Examples of Ineligible HSA Expenses

Your Health Savings Account lets you pay for medical care expenses not covered by your insurance plan with pre-tax dollars. The Internal Revenue Service (IRS) defines medical care expenses as amounts paid for the diagnosis, cure or treatment of a disease, and for treatments affecting any part or function of the body.

The items listed below are examples of products and services that are NOT eligible for reimbursement under your HSA, according to the IRS. Typically, expenses for items that promote general health are not eligible expenses. Please note that this list is not all-inclusive and is subject to change.

- Baby sitting, childcare, and nursing services for a normal, healthy baby
- Controlled substances
- Cosmetic surgery
- Dancing lessons
- Diaper service
- Electrolysis or hair removal
- Flexible spending arrangements
- Funeral expenses
- Future medical care
- Hair transplant
- Health club dues
- Health savings accounts
- Household help
- Illegal operations and treatments
- Insurance premiums
- Maternity clothes
- Medical savings accounts
- Medicines and drugs from other countries
- Nonprescription drugs and medications (except for insulin)
- Nutritional supplements
- Personal use items
- Premium tax credit
- Swimming lessons
- Teeth whitening
- Veterinary fees
- Weight-loss program

Source: www.irs.gov

The Difference Card

Employee FAQ:

Health Savings Accounts

What is a health savings account (HSA)?

An HSA is a tax-advantaged personal savings account that can be used to pay for medical, dental, vision and other qualified expenses now or later in life. To contribute to an HSA, you must be enrolled in a qualified high-deductible health plan (HDHP) and your contributions are limited annually. The funds can even be invested, making it a great addition to your retirement portfolio.

Why should I participate in an HSA?

High-deductible health plans typically have lower monthly premiums and greater out-of-pocket costs. An HSA helps offset those costs and ensure you have money set aside to pay for out-of-pocket healthcare expenses. HSA contributions can be made pre-tax via payroll contributions, or post-tax – which simply means you can reap the tax benefit when you file your income taxes. Either way, you're saving an average of 30% and making your healthcare dollars stretch further. But an HSA is also a powerful investment vehicle and can be a smart addition to your retirement strategy. You will never be taxed when you use HSA dollars for qualified medical expenses. No other investment account offers this benefit!

Am I eligible to contribute to my HSA?

To contribute to an HSA, you must be enrolled in a qualified HDHP, not covered under a secondary health insurance plan, not enrolled in Medicare, and not another person's dependent.

What is a high-deductible health plan?

The IRS defines HSA-eligible plans, also known as qualified high-deductible health plans (HDHPs), as those that have a deductible of at least $1,600 for an individual and $3,200 for a family and have an out-of-pocket maximum that does not exceed $7,500 for individual or $15,000 for family coverage.

How do I contribute money to my HSA?

Most employers offer a payroll deduction through a Section 125 Cafeteria Plan, allowing you to make contributions to your HSA on a pre-tax basis. The contribution is deposited into your HSA prior to taxes being applied to your paycheck, making your savings immediate. You can also contribute to your HSA post-tax and recognize the same tax savings by claiming the deduction when filing your annual taxes.

How much can I contribute to my HSA?

Contributions can be made by the eligible employee, their employer, or any other individual. Annual contributions from all sources may not exceed $4,150 for singles or $8,300 for families in 2024. Individuals aged 55 and over may make an additional $1,000 catch-up contribution.

Can I change my contributions to my HSA during the year?

You can change your election amount at any time during the plan year. You're not "locked in" to the amount you selected during your open enrollment period.

What can I spend my HSA funds on?

You can use your HSA to pay for eligible healthcare, dental, and vision expenses for yourself, your spouse, or eligible dependents. The IRS provides specific guidance regarding eligible expenses. (See IRS Publication 502).

How do I access the funds in my HSA?

Use your The Difference Card for eligible healthcare expenses or pay with your personal funds and reimburse yourself with money from your HSA.

Do I have to spend all my contributions by the end of the plan year?

Unlike a flexible spending account (FSA), unused money in your HSA isn't forfeited at the end of the year; it continues to grow, tax-free.

What happens if my employment is terminated?

If you get laid off, furloughed from your job or choose to leave, your account and funds stay with you and you can always use your HSA dollars to help pay for qualified medical costs.

What happens to my money if I'm no longer in an HSA-eligible health plan?

Once you discontinue coverage under an HSA-eligible health plan and/ or get secondary health insurance coverage that disqualifies you from an HSA, you can no longer make contributions to your HSA. However, since you own the HSA, you can continue to use the remaining funds for future healthcare expenses.

When must contributions be made to an HSA for a taxable year?

Contributions for the taxable year can be made in one or more payments at any time after the year has begun and prior to the individual's deadline (without extensions) for filing the eligible individual's federal income tax return for that year. For most taxpayers, the deadline is April 15 of the year following the year for which contributions are made.

Is tax reporting required for an HSA?

Yes. IRS form 8889 must be completed with your tax return each year to report total deposits and withdrawals from your account. You do not have to itemize to complete this form.

Can I use my HSA for non-healthcare purchases?

If you withdraw money for an unqualified expense prior to age 65, you'll be subject to your ordinary income tax, in addition to a 20% tax penalty. You can withdraw the money for any reason without penalty after age 65 but are subject to applicable income taxes.

How does a limited purpose flexible spending account (LPFSA) work with my HSA?

An LPFSA allows you to set aside pre-tax dollars for dental and vision expenses. You are eligible to open an LPFSA if you are enrolled in an HSA. By using your LPFSA for dental and vision expenses, you can preserve your HSA funds for growth and maximize your long-term savings.

Can I invest my HSA funds for growth?

Yes. Once your HSA cash account balance reaches $1,000, you can invest your funds like a 401(k). But unlike a 401(k), you will never pay taxes on withdrawals for qualified expenses, making your HSA a powerful investment vehicle to help you prepare for future healthcare expenses, even into retirement.

Can I move funds from my investment account to my HSA cash account?

Yes. You can move your investment funds to you HSA cash account at any time.

What type of investment options are provided?

Your The Difference Card HSA gives you access to WealthCare Investments – a modern investment experience with features and functionality new to HSAs. You can manage all aspects of your HSA, including your investments, from a single platform. You can choose from three investment paths to suite your needs and experience level: Managed, Self-Directed, and Brokerage.

Is investing my HSA the only way to maximize my contributions?

No. Unused funds in your HSA cash account will earn interest and grow tax-free. You can choose the interest option to meet your needs: High-Yield or Traditional. The High-Yield interest option can help you earn higher interest on your HSA cash balance.

For more information, call (888) 343-2110

The Difference Card

PO Box 322 • Mount Kisco, NY 10549 • www.differencecard.com

Flexible Spending Account

Paying for health care can be stressful. That's why we are offering our employees an employer-sponsored flexible spending account (FSA).

What are the benefits of an FSA?

There are a variety of different benefits of using an FSA, including the following:

- **It saves you money**. Allows you put aside money tax-free that can be used for qualified medical expenses –up to $3,300 for 2025.
- **It's a tax-saver**. Since your taxable income is decreased by your contributions, you'll pay less in taxes.
- **It is flexible**. You can use your FSA funds at any time, even if it's the beginning of the year.

You cannot stockpile money in your FSA. **If you do not use it, you lose it.** You should only contribute the amount of money you expect to pay out of pocket that year.

Limited Purpose FSA

Individuals/families that are taking advantage of a High Deductible Health Plan with a Health Savings Account option can still use tax-deferred dollars to cover qualified dental and vision expenses with the limited purpose FSA.

What is a dependent care FSA?

Dependent Care FSAs allow you to contribute pre-tax dollars to qualified dependent care. The maximum amount you may contribute each year is $5,000 (or $2,500 if married and filing separately).

How do I enroll?

Fill out the FSA Enrollment Form during Open Enrollment. Even if you signed up last year, you must re-enroll for 2025.

FSA Case Study

FSAs provide you with an important tax advantage that can help you pay for certain expenses on a pre-tax basis. Due to the personal tax savings you incur, your spendable income will increase. The example that follows focuses on how a health FSA can save you money.

Bob and Jane have a combined annual gross income of $45,000. They are married and file their income taxes jointly. Since Bob and Jane expect to spend $3,000 in eligible medical expenses in the next plan year, they decide to direct a total of $2,850 into their FSAs. The table demonstrates their savings.

	Without health FSA	With health FSA
Gross income	**$45,000**	**$45,000**
FSA contributions	$0	(-$2,850)
Gross income	$45,000	$42,150
Estimated taxes	(-$5,532)*	(-$5,058)*
After-tax earnings	**$39,468**	**$37,092**
Eligible out-of-pocket expenses	(-$3,000)	(-$150)
Remaining spendable income	**$36,468**	**$36,942**
Spendable income increase	--	**$342**

This example is for illustrative purposes only and assumes standard deductions for state and federal taxes and four exemptions. It assumes a state income tax of 12% which may vary. Every situation is different therefore it is recommended that you contact your tax professional if you have questions or need advice.

Flexible Spending Account

Which expenses can be reimbursed by an FSA?

Your Health Care Reimbursement Flexible Spending Account lets you pay for medical care expenses not covered by your insurance plan with pre-tax dollars. The expenses must be primarily to alleviate a physical or mental defect or illness, and be adequately substantiated by a medical practitioner. The products and services listed below are examples of medical expenses eligible for payment under your FSA, to the extent that such services are not covered by your medical and dental insurance plan.

Unfortunately, **we cannot provide a definitive list of "qualified medical expenses."** A determination of whether an expense is for "medical care" is based on all the relevant facts and circumstances. To be an expense for medical care, the expense has to be primarily for the prevention or alleviation of a physical or mental defect or illness.

You will find additional information via the source link below, including a list of items that are generally not eligible for reimbursement. The following are examples of FSA-eligible expenses (this is not an exhaustive list):

- Acupuncture
- Alcoholism treatment
- Ambulance
- Annual physical examination
- Artificial limb
- Artificial teeth
- Bandages
- Birth control pills
- Body scan
- Braille books and magazines
- Breast pumps and supplies
- Breast reconstruction surgery
- Capital expenses (improvements or special equipment installed to a home, if meant to accommodate a disabled condition)
- Car modifications or special equipment installed for a person with a disability
- Chiropractor
- Christian Science practitioner
- Contact lenses
- Crutches
- Dental treatment (not including teeth whitening)
- Diagnostic devices
- Disabled dependent care expenses
- Drug addiction treatment
- Eye exam
- Eye-glasses
- Eye surgery
- Fertility enhancement (in vitro fertilization or surgery)
- Guide dog or other service animal
- Health institute fees (if treatment is prescribed by a physician)
- Intellectually or developmentally disabled care, treatment or special home
- Laboratory fees
- Lactation expenses
- Lead-based paint removal (if a child in the home has lead poisoning)
- Learning disability care or treatment
- Legal fees associated with medical treatment
- Lifetime care, advance payments or "founder's fee"
- Lodging at a hospital or similar institution
- Medical conference expenses, if the conference concerns a chronic illness of yourself, your spouse or your dependent
- Medical information plan
- Medications, if prescribed
- Nursing services
- Operations
- Optometrist
- Organ donors
- Osteopath
- Oxygen
- Personal protective equipment used for the primary purpose of preventing the spread of COVID-19
- Physical examination
- Pregnancy test kit
- Prosthesis
- Psychiatric care
- Psychoanalysis
- Psychologist
- Special education
- Sterilization
- Stop-smoking programs
- Surgery
- Special telephone for hearing-impaired individual
- Television for hearing-impaired individuals
- Therapy received as medical treatment
- Transplants
- Transportation for medical care
- Tuition for special education
- Vasectomy
- Vision correction surgery
- Weight-loss program if it is a treatment for a specific disease
- Wheelchair
- Wig
- X-ray

Fully FSA Eligible effective 1/1/2020:

- **Over-the-counter medicines**
- **Menstrual care products**

Source: www.irs.gov/publications/p502/ar02.html#en_US_publink1000178947

Difference Card Guide:
Flexible Spending Accounts

What is an FSA?
A healthcare flexible spending account (FSA) is an employer-sponsored benefit that allows you to set aside pre-tax dollars into an account to be used for eligible medical expenses.

Why should I participate in an FSA?
Contributions to the FSA are deducted from your paycheck on a pre-tax basis, reducing your taxable income. You can increase your spendable income by an average of 30% of your annual contribution with the tax savings.

How do I contribute money to my FSA?
Your annual election will be divided by the number of pay periods in your plan year. This amount will be deducted from your paycheck before taxes are assessed.

Who is eligible under an FSA?
An FSA covers eligible expenses for you and all of your dependents, even if they are not covered under your primary health plan.

What expenses are eligible for reimbursement?
Health plan co-pays, deductibles, co-insurance, eyeglasses, dental care, and certain medical supplies are covered. The IRS provides specific guidance regarding eligible expenses. (See IRS Publication 502). Visit FSAStore.com to see a list of eligible items.

How do I determine the date my expenses were incurred?
Expenses are incurred at the time the medical care was provided, not when you are invoiced or pay the bill.

How do I get the funds out of my FSA?
If you have a Difference Card, simply swipe it at the register. If you do not have your card on hand, you can submit for a reimbursement against your FSA for eligible out of pocket expenses via Mobile App or on the Difference Card site. Once approved, your reimbursement check will be mailed or deposited into your bank account.

How much can I contribute?
You can find the max contribution rates for the year here: DifferenceCard.com/Services/Products/Fsa/

What happens if I don't spend all of my FSA by the end of the plan year?
Check in with your employer to see what policy they have adopted for this elected benefit.

How soon can I start spending my FSA funds?
With a healthcare FSA, your entire annual election amount is available on the first day of the plan year even though you have not yet contributed that amount.

Can I change my election amount mid-year?
Elections can only be altered if you experience a change in status as defined by IRS regulations, such as marriage, divorce, birth, or death in your immediate family.

What happens to my FSA if my employment is terminated?
Participation in your FSA is also terminated. This means that only expenses that were incurred prior to your termination date are eligible for reimbursement.

What is the deadline for submitting claims?
Check in on your Mobile App or DC account for exact deadline dates. Generally, you have 90 days after your plan ends to submit a claim for reimbursement. You can also submit claims at any time during the same plan year that you incur the expense.

Can I still deduct healthcare expenses on my tax return?
Yes, but not the same expenses for which you have already been reimbursed from your FSA.

Are Over-the-Counter (OTC) medications eligible for reimbursement?
Yes. OTC medicines like Tylenol®, Zyrtec® and more will now be available for purchase with an FSA without a prescription.

What is another new change for eligible expenses?
Menstrual care products, such as tampons and pads, are now considered qualified health expenses with your FSA.

Visit DifferenceCard.com/Services/Products/Fsa/ for more info.

Employee FAQ:
Dependent Care FSA

What is a Dependent Care FSA (DCA)?

A DCA is a flexible spending account that allows you to contribute a portion of your paycheck before taxes are taken out to pay for qualified dependent care expenses so that you can work or look for work.

Why should I participate?

Since contributions to the account are deducted from your paycheck before income taxes are assessed, your taxable income is reduced. Participants enjoy a 30% average tax savings on the total amount they contribute to the account.

How do I contribute money to my DCA?

Once you make your annual election during open enrollment, your employer will deduct this amount from your paycheck before taxes are assessed in equal amounts throughout the year.

How much can I contribute?

The IRS limits annual contributions to $5,000 on income tax returns for single or married filing jointly, and $2,500 for married filing separately.

Who qualifies as a dependent?

You can use your DCA to pay for care for children 12 and under that you claim as dependents, as well as adults or other relatives that are incapable of caring for themselves (if you provide more than 50% of their support).

What type of care is eligible?

Eligible expenses must be for the purpose of allowing you to work or look for work. Services may be provided at a child or adult care center, nursery, preschool, after--school, summer day camp, or a nanny in your home. The person providing the service must claim it as taxable income.

What type of care is not eligible?

Care expenses that are not eligible to be paid with DCA funds include care for a child over age 13, overnight camp, babysitting that is not work related, school fees for kindergarten and higher grades, and long--term care services.

Do I have access to my entire DCA election amount at the beginning of the year?

No, you will only have access to DCA funds that have already been deducted from your paycheck.

Are there any rules about who can care for my dependents?

Yes. You can not use funds to pay for care provided by a spouse, a person you list as a dependent for income tax purposes, or one of your children under the age of 19.

How do I use the funds in my account?

If you have a benefits debit card and your care provider accepts credit cards, you may pay directly from your account. Otherwise, pay outb ofb pocket and then file a reimbursement claim with your expense documentation.

What happens if I don't spend all of my DCA funds by the end of the plan year?

It is essential to estimate conservatively during elections. Depending on what your employer allows, you may have 2.5 additional months to incur expenses after the end of the plan year

Can I change my election amount mid-year?

Typically, you cannot change your contribution midb year. However, if you experience a qualifying event, such as the birth of a new child, or if your child care provider significantly increases their rates, you may be eligible to adjust your contribution.

What happens to my account if my employment is terminated?

Participation in the plan is also terminated. This means that only expenses that were incurred prior to your termination date are eligible for reimbursement.

Visit DifferenceCard.com/services/products/dependent-care/ for more info.

The Difference Card

Your Team of Advocates

When you have questions about your benefits, North Risk Partners is at your service.

Hours of Operation are 8:00 am – 4:30pm CST

Contact your team when you:

- Need assistance in processing, disputing or understanding a claim
- Have questions concerning provider access and/or provider directories
- Need interpretation of a benefit provision or comparison of plans
- Need an ID card for you, your spouse, or a dependent
- Have any other employee benefit questions, concerns or inquiries

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Understanding Your EOB

After submitting a claim for treatment, you may receive an Explanation of Benefits (EOB) from your insurance company. The EOB is a form that insurance companies send to their members to explain what part of a claim was paid by insurance, what part was not paid, and why. It is important to understand what this statement means.

Many people find EOBs difficult to understand since they differ from one insurance company to another. Some insurance companies combine several dates of service or several providers on a single EOB form. Others prepare separate forms for each date of service and provider you see.

Typically, most EOBs include the following information:

- Name and address of the policyholder
- Name of the patient
- The group number
- The member ID number
- Claim number
- Date the claim was processed
- Date of service
- Name of the health care facility and the provider name
- Name of the procedure or service and the billing code
- Amount that was billed to the insurer by the provider
- The portion of the bill that is eligible for insurance coverage
- The reason why the non-covered portion was not covered
- The amount of the charges that are subject to the patient's deductible
- The amount paid by insurance company

The main purpose of your EOB is to help you determine if your claim has been paid, how much has been paid by your insurance company, and how much is your responsibility. Then, you will know which invoices to pay and how much.

To figure out who has been paid, match the treatment dates and providers from the invoices to the dates of service and providers listed on your EOB. Make sure your provider gives you an itemized invoice so you can effectively match your EOB to your invoices.

Keep in mind that insurance companies rarely pay 100% of a claim. You need to pay your part in applicable deductibles, coinsurance and copayments.

Below are some common reasons for partial payment of a claim by your insurance company:

- Part or all of the claim was charged to you to satisfy your deductible
- Part of the claim was charged to you in the form of a copayment
- Part or all of the claim was charged to you to satisfy your coinsurance requirement
- The charges for the services exceeded the maximum benefit available for the service
- Your insurance policy was not in force on the date of service
- The claim was a duplicate and had been previously paid
- The charges exceeded the insurance company's reasonable and customary limitation (this happens more frequently when using out-of-network providers)
- The charges are for a non-covered service (i.e., cosmetic surgery)
- The charge was for a pre-existing medical condition that is excluded from coverage

If you receive an EOB showing that your insurance company did not pay for your entire claim, first determine the reason why, and then determine if the reason is valid. If you believe there has been an error, contact your health plan's member services department to ask them to review the claim.

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.