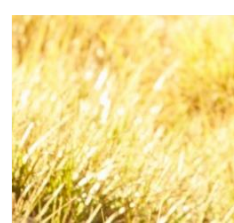
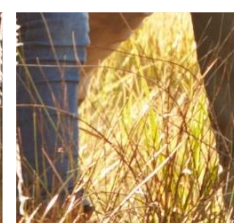
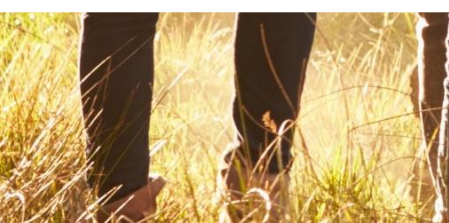
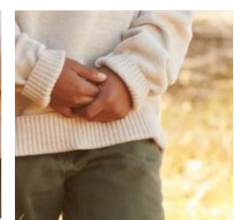
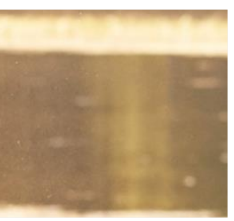


Classified Part-Time Staff

EMPLOYEE BENEFITS

2024-2025



CHIP 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 Glenwood Community School District, 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 on the following page, 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, dial **1-877-KIDS NOW**, or visit 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, 2024. Contact your State for more information on eligibility.

To see if any other states have added a premium assistance program since January 31, 2024 or for more information on special enrollment rights, contact either:

**U.S. Department of Labor
Employee Benefits Security Administration**
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

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

State	Website/E-mail	Phone
Alabama (Medicaid)	http://www.myalhipp.com/	1-855-692-5447
Alaska (Medicaid)	Premium Payment Program: http://myakhipp.com/ Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx E-mail: CustomerService@MyAKHIPP.com	1-866-251-4861
Arkansas (Medicaid)	http://myarhipp.com/	1-855-692-7447
California (Medicaid)	http://dhcs.ca.gov/hipp hipp@dhcs.ca.gov	916-445-8322 916-440-5676 (fax)
Colorado (Medicaid and CHIP)	Medicaid: https://www.healthfirstcolorado.com/ CHIP: https://hcpf.colorado.gov/child-health-plan-plus HIBI: https://www.mycohibi.com/	1-800-221-3943 1-800-359-1991 1-855-692-6442 State relay 711
Florida (Medicaid)	https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html	1-877-357-3268

State	Website/E-mail	Phone
Georgia (Medicaid)	HIPP: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp CHIPRA: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra	678-564-1162, press 1 678-564-1162, press 2
Indiana (Medicaid)	Healthy Indiana Plan for low-income adults 19-64: http://www.in.gov/fssa/hip/ All other Medicaid: https://www.in.gov/medicaid	1-877-438-4479 1-800-457-4584
Iowa (Medicaid and CHIP)	Medicaid: https://dhs.iowa.gov/ime/members CHIP: http://dhs.iowa.gov/Hawki HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp	1-800-338-8366 1-800-257-8563 1-888-346-9562
Kansas (Medicaid)	https://www.kancare.ks.gov/	1-800-967-4660 HIPP: 1-800-967-4660
Kentucky (Medicaid and CHIP)	Medicaid: https://chfs.ky.gov/agencies/dms KI-HIPP: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx KI-HIPP E-mail: KIHIPPPROGRAM@ky.gov KCHIP: https://kynect.ly.gov	1-855-459-6328 1-877-524-4718
Louisiana (Medicaid)	www.medicaid.la.gov www.ldh.la.gov/lahipp	1-888-342-6207 1-855-618-5488
Maine (Medicaid)	https://www.maine.gov/dhhs/ofi/applications-forms https://www.mymaineconnection.gov/benefits/s/?language=e_n_US	Enroll: 1-800-442-6003 Private HIP: 1-800-977-6740 TTY: Maine relay 711
Massachusetts (Medicaid and CHIP)	https://www.mass.gov/masshealth/pa Email: masspremassistance@accenture.com	1-800-862-4840 TTY: 711
Minnesota (Medicaid)	https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp	1-800-657-3739
Missouri (Medicaid)	http://www.dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
Montana (Medicaid)	http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP HSHIPPPProgram@mt.gov	1-800-694-3084
Nebraska (Medicaid)	http://www.ACCESSNebraska.ne.gov	1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
Nevada (Medicaid)	http://dhcfp.nv.gov/	1-800-992-0900
New Hampshire (Medicaid)	https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program	603-271-5218 or 1-800-852-3345, ext. 5218
New Jersey (Medicaid and CHIP)	Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ CHIP: http://www.njfamilycare.org/index.html	Medicaid: 609-631-2392 CHIP: 1-800-701-0710
New York (Medicaid)	https://www.health.ny.gov/health_care/medicaid/	1-800-541-2831
North Carolina (Medicaid)	https://medicaid.ncdhhs.gov/	919-855-4100
North Dakota (Medicaid)	https://www.hhs.nd.gov/healthcare	1-844-854-4825
Oklahoma (Medicaid and CHIP)	http://www.insureoklahoma.org	1-888-365-3742
Oregon (Medicaid)	http://healthcare.oregon.gov/Pages/index.aspx	1-800-699-9075
Pennsylvania (Medicaid and CHIP)	Medicaid: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx CHIP: https://www.dhs.pa.gov/chip/pages/chip.aspx	Medicaid: 1-800-692-7462 CHIP: 1-800-986-KIDS (5437)
Rhode Island (Medicaid and CHIP)	http://www.eohhs.ri.gov/	1-855-697-4347 or 401-462-0311 (Direct Rlte)
South Carolina (Medicaid)	https://www.scdhhs.gov	1-888-549-0820
South Dakota (Medicaid)	http://dss.sd.gov	1-888-828-0059
Texas (Medicaid)	https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program	1-800-440-0493
Utah (Medicaid and CHIP)	Medicaid: https://medicaid.utah.gov/ CHIP: http://health.utah.gov/chip	1-877-543-7669
Vermont (Medicaid)	https://dvha.vermont.gov/members/medicaid/hipp-program	1-800-250-8427
Virginia (Medicaid and CHIP)	https://coverva.dmas.virginia.gov/learn/premiumassistance/famis-select https://coverva.dmas.virginia.gov/learn/premiumassistance/health-insurance-premium-payment-hipp-programs	1-800-432-5924
Washington (Medicaid)	https://www.hca.wa.gov/	1-800-562-3022
West Virginia (Medicaid)	https://dhhr.wv.gov/bms/ http://mywvhipp.com/	Medicaid: 304-558-1700 CHIP: 1-855-699-8447
Wisconsin (Medicaid and CHIP)	https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm	1-800-362-3002
Wyoming (Medicaid)	https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/	1-800-251-1269



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his benefit summary describes the benefit plans available to you as an employee of Glenwood CSD.

The details of these plans are contained in the official plan documents that have been provided to you by your employer, including some insurance contacts. This summary is meant only to cover the highlights of each plan.

If there is ever a question about one of these plans, or if there is a conflict between the information in this summary and the formal language of the plan documents, the formal wording in the plan documents will govern. Please note that the benefits described in the summary may be changed at any time and do not represent a contractual obligation on the part of Glenwood CSD.

Welcome!



We are committed to providing competitive benefit programs that are flexible enough to meet your individual needs. Our comprehensive benefits are carefully designed to give you the tools you need to keep you and your family healthy, provide financial protection in the event of unforeseen circumstances and help you build long-term security for retirement.

Getting the most from your benefits is up to you. You know your family, your goals and your lifestyle best.

This benefits guide was designed to answer some of the basic questions you may have about your benefits. Please take the time to review this guide to make sure you understand the benefits that are available to you and your family and be sure to act before the enrollment deadline.

Open Enrollment: Take Action!

May 8th – May 24th

This Open Enrollment is an **active enrollment**, meaning all employees must complete the Wellmark enrollment form to have coverage in the new plan year.



Eligibility

Benefit Eligibility

You and your eligible family members may participate in the 2024 employee benefits program if you're a regular, full-time employee working a minimum of **30-40 hours** per week.



Dependent Eligibility

You can enroll the following dependents in our group benefit plans:

- Your legal spouse
- Children up to age 26*
- A child under the age of 26 who is your natural child, stepchild, legally adopted child, or child for whom you have obtained legal guardianship
- Unmarried children of any age if totally disabled and claimed as a dependent on your federal income tax return (documentation of handicapped status must be provided)

* Enrolled children lose coverage when they turn 26 and will be mailed COBRA enrollment information.

New-Hire Eligibility

New hires can join the plan the first of the month following date of hire. Spouses and dependent children of the employees are also eligible to participate in our benefit plans.





Qualifying Life Event

Your benefit elections made during Open Enrollment will be effective July 1, 2024. You may not make changes to your elections until the next open enrollment period, unless you experience a qualifying life event, including change in legal marital status (marriage, divorce, death of spouse), change in dependents (birth, adoption), change in employment status (termination, part-time), or your spouse's Open Enrollment.



Important

If you need to make a change before the next Open Enrollment period due to a change in status, you must submit the required documentation **WITHIN 30 DAYS** of the qualifying life change event.

Contact **Debbie Schoening** to process a Qualifying Life Event.

Medical Plan

Wellmark Blue Cross Blue Shield		\$500 PPO	
Calendar Year	Deductible	IN-NETWORK	OUT-OF-NETWORK
Individual		\$500	
Family		\$1,000	
Out of Pocket Maximum			
Individual		\$1,000	
Family		\$2,000	
Coinsurance / Copays			
Preventive Care		Covered at 100%	Deductible, 40% Coinsurance
Primary Care Physician		\$10 Copayment	Deductible, 40% Coinsurance
Specialist		\$10 Copayment	Deductible, 40% Coinsurance
Urgent Care		\$10 Copayment	Deductible, 40% Coinsurance
Emergency Room		\$200 Copayment	\$200 Copayment
Inpatient Facility Services		Deductible, 20% Coinsurance	Deductible, 40% Coinsurance
Outpatient Facility Services		Deductible, 20% Coinsurance	Deductible, 40% Coinsurance
Pharmacy (Blue Rx Value Plus Drug List)			
Prescription Drug Deductible (applies to all tiers except Tier 1)		\$50 Single/\$100 Family	
Tier 1		\$10 Copayment	Not Covered
Tier 2		\$20 Copayment	
Tier 3		\$20 Copayment	
Specialty		\$85 Copayment	
Mail Order			
Tier 1/ Tier 2/ Tier 3		2 Copayments	Not Covered

Please note: If you go to an out-of-network provider, your cost may be higher and your provider may ask you to pay the actual charge for your care at the time of your visit.

Medical Plan

Wellmark Blue Cross Blue Shield		\$1,000 PPO	
Calendar Year Deductible	IN-NETWORK	OUT-OF-NETWORK	
Individual	\$1,000		
Family	\$2,000		
Out of Pocket Maximum			
Individual	\$2,000		
Family	\$4,000		
Coinsurance / Copays			
Preventive Care	Covered at 100%	Deductible, 40% Coinsurance	
Primary Care Physician	\$15 Copayment	Deductible, 40% Coinsurance	
Specialist	\$15 Copayment	Deductible, 40% Coinsurance	
Urgent Care	\$15 Copayment	Deductible, 40% Coinsurance	
Emergency Room	\$200 Copayment	\$200 Copayment	
Inpatient Facility Services	Deductible, 20% Coinsurance	Deductible, 40% Coinsurance	
Outpatient Facility Services	Deductible, 20% Coinsurance	Deductible, 40% Coinsurance	
Pharmacy (Blue Rx Value Plus Drug List)			
Prescription Drug Deductible (applies to all tiers except Tier 1)	\$50 Single/\$100 Family	Not Covered	
Tier 1	\$10 Copayment		
Tier 2	\$20 Copayment		
Tier 3	\$20 Copayment		
Specialty	\$85 Copayment		
Mail Order			
Tier 1/ Tier 2/ Tier 3	2 Copayments	Not Covered	

Please note: If you go to an out-of-network provider, your cost may be higher and your provider may ask you to pay the actual charge for your care at the time of your visit.

Medical Plan

Wellmark Blue Cross Blue Shield		\$3,500 PPO HDHP	
Calendar Year	Deductible	IN-NETWORK	OUT-OF-NETWORK
Individual		\$3,500	
Family		\$7,000	
Out of Pocket Maximum			
Individual		\$3,500	
Family		\$7,000	
Coinsurance / Copays			
Preventive Care		Covered at 100%	Deductible, 0% Coinsurance
Primary Care Physician		Deductible, 0% Coinsurance	Deductible, 0% Coinsurance
Specialist		Deductible, 0% Coinsurance	Deductible, 0% Coinsurance
Urgent Care		Deductible, 0% Coinsurance	Deductible, 0% Coinsurance
Emergency Room		Deductible, 0% Coinsurance	Deductible, 0% Coinsurance
Inpatient Facility Services		Deductible, 0% Coinsurance	Deductible, 0% Coinsurance
Outpatient Facility Services		Deductible, 0% Coinsurance	Deductible, 0% Coinsurance
Pharmacy (Blue Rx Value Plus Drug List)			
Tier 1		Deductible, 0% Coinsurance	Not Covered
Tier 2			
Tier 3			
Specialty			
Mail Order			
Tier 1/ Tier 2/ Tier 3		Deductible, 0% Coinsurance	Not Covered

Please note: If you go to an out-of-network provider, your cost may be higher and your provider may ask you to pay the actual charge for your care at the time of your visit.

If you enroll in the_HDHP plan, Glenwood CSD will contribute **\$100 per month into your HSA.

DOCTOR ON DEMAND BENEFITS

With Doctor on Demand, you can schedule a virtual appointment with board-certified doctors and pediatricians who can diagnose, treat and prescribe most medications for minor medical conditions, such as:

- Acne
- Allergies infections
- Asthma
- Bronchitis
- Cold and flu
- Constipation
- Diarrhea
- Earaches
- Fever
- Headache
- Infections
- Insect bites
- Joint aches
- Nausea
- Pink Eye
- Rashes
- Respiratory infections
- Shingles
- Sinus
- Skin infections
- Sore throats
- Urinary tract infections



We've all been there — it's the middle of the night and you have a sick child or maybe you are trying to get an appointment with your primary care provider, but the first appointment isn't for two weeks. Good news... there's an easier way!

Doctor on Demand is a convenient option for scheduling virtual doctor visits from your own home. With Doctor on Demand, you don't have to drive to the doctor's office or sit in a waiting room when you're sick— you can see your doctor from the comfort of your own bed or sofa. Simply download the **Doctor on Demand app** or visit **DoctorOnDemand.com**.



In addition, you can:

- See a board-certified, licensed, telehealth trained doctor on your schedule with on-demand virtual visits 24/7, including holidays.
- Get a prescription or short-term refill of any existing prescription sent to a pharmacy nearby, in less time than your usual doctor visit.
- Get treated for more than 80 common conditions including colds, flu, allergies and more.
- Avoid costly copays and deductibles of the ER and urgent care clinic.

HEALTH SAVINGS ACCOUNT (HSA)

For a list of eligible expenses, see IRS Publication 502, available at www.irs.gov.

WHAT IS A HEALTH SAVINGS ACCOUNT?

A Health Savings Account (HSA) is a way for you to save pre-tax dollars that can be used to pay for qualified healthcare expenses like deductibles, copays, co-insurance, prescriptions, vision and dental expenses. High deductible health plans have lower premiums and may result in lower annual medical costs. These plans offer several advantages to reward you for taking an active role in your healthcare spending.

- **Triple tax advantage**— money goes in tax-free, money grows tax-free, and money goes out tax-free as long as it's used for qualified medical, dental, and vision expenses.
- **Funds roll over each year**
- **You own your HSA**
- **Investment options are available after you reach a certain dollar amount**
- **Comparable benefits** — these plans use the same networks that other plans offer, and in-network preventive care is still 100% covered

WHO IS ELIGIBLE FOR AN HSA?

- Must be enrolled in a high deductible health plan
- Cannot be covered by any other medical plan that is not a qualified HDHP. This includes a spouse's medical coverage unless it's also a qualified HDHP
- Cannot be enrolled in a traditional health care FSA, but you may enroll in a Limited Purpose FSA
- Cannot be enrolled in Medicare, including Parts A or B, Medicaid or Tricare
- Cannot be claimed as a dependent on another person's tax return
- Cannot be a veteran who has received treatment, other than preventive care, through the Department of Veterans Affairs within the past three months

HOW MUCH CAN I CONTRIBUTE TO AN HSA?

- Employee only coverage: \$4,150 per calendar year
- Employee plus dependents coverage: \$8,300
- If you are 55 or older, you can make an additional annual catch-up contribution of \$1,000

HSAs AND YOUR TAXES

All withdrawals from your HSA are tax-free, as long as you use the money to pay for eligible health care expenses. In addition, all the money in the account is yours and will never be forfeited. It rolls over from year to year, and you can take it with you if you leave the company or retire. After age 65, you can withdraw funds for any reason without a tax penalty — you pay ordinary income tax only if the withdrawal isn't for eligible health care expenses.

Note: You won't pay federal taxes on HSA contributions. However, you may pay state taxes depending on your residence. Consult your tax advisor to learn more.



Employee Assistance Program

We understand that we all face serious problems at some time in our lives and Glenwood CSD is committed to providing help during those times.

The EAP is designed to assist staff members and families with personal challenges in many different areas including: depression, stress management, drug and alcohol abuse, relationships, grief, domestic violence, legal and financial issues, parenting, childcare and elder care.

Participation in the EAP is voluntary, confidential and free of cost . For those who require referrals for long-term treatment, there may be fees for the services of outside providers. However, EAP counselors will coordinate referrals, whenever possible, to take advantage of existing insurance coverage and community resources in order to minimize costs. We encourage you and your eligible family members to take advantage of our EAP benefit and to reach out to **Best Care**.

A white line-art icon on a black background showing a mobile phone with two speech bubbles, representing 24/7 support.

24 Hours A Day, 7 Days A Week

Professional counselors are available to provide you with support, guidance and resources.

How do I Enroll?

1. Review

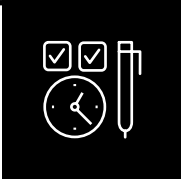
Read through the information in this booklet.

2. Choose Your Plan

Utilize this booklet to help choose the lowest-cost, best-value health plan based on your medical needs.

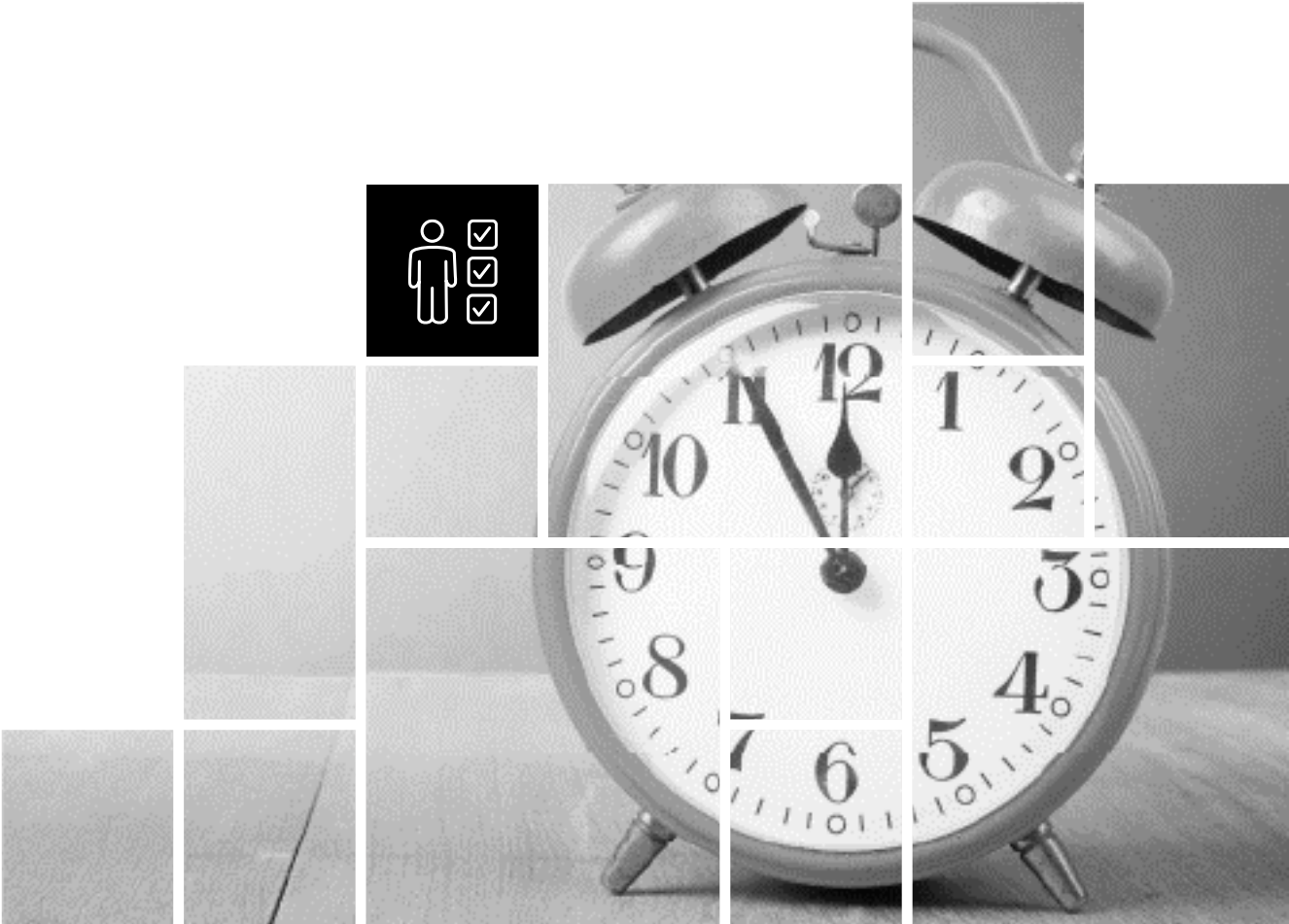
3. Enroll

Based off the best value plan for your needs, enroll in your benefits by completing the included enrollment forms.



Reminder:

- Qualifying Life Events must be completed within 30 days of your event.



Benefits Definitions

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is \$100 and you've met your deductible, your coinsurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.)

Copayment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service (sometimes called "copay"). The amount can vary by the type of covered health care service.

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible.)

Network

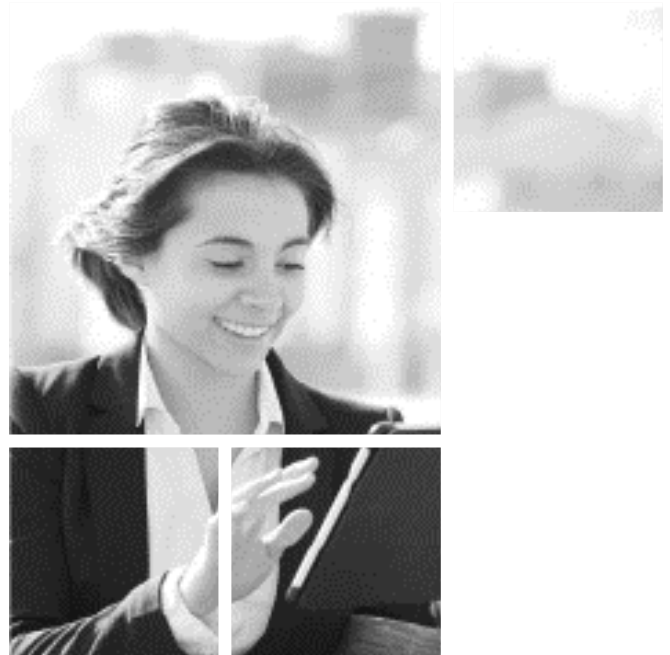
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Network Provider

A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

Out-of-Network Provider

A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider."



Benefits Definitions (cont.)

Out-of-Pocket Maximum

The most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

Premium

The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.



Important Contacts

Coverage	Contact	Phone	Website
Medical	Wellmark	800-524-9242	www.wellmark.com
Health Savings Account	Health Equity	800-383-1623	www.healthequity.com
Employee Assistance Program	Best Care	800-666-8606	www.bestcareEAP.org
Human Resources	Debbie Schoening	712-527-9034 (ext. 1000)	schoeningd@glenwoodschoools.org
Holmes Murphy Contact	Amanda Bellville	515-223-6825	ABellville@holmesmurphy.com
Holmes Murphy Contact	Nikki Endicott	515-223-6864	NEndicott@holmesmurphy.com




Glenwood CSD PPO Plan 1



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.wellmark.com or call 1-800-524-9242. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-524-9242 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$500 person/\$1,000 family per calendar year.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Well-child care, in-network preventive care, in-network independent labs, routine vision exams, in-network prosthetic limbs, colonoscopy or sigmoidoscopy performed in the office or outpatient facility and services subject to copayments are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. \$50 person/\$100 family per calendar year for drug card, which does not apply to Tier 1 Rx. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Health: \$1,000 person/\$2,000 family per calendar year. Drug Card: \$1,000 person/\$2,000 family per calendar year. The In-Network health and drug card out-of-pocket maximum amounts accumulate together.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why this Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.wellmark.com or call 1-800-524-9242 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay In-Network (<u>IN</u>) <u>Provider</u> (You will pay the least)	What You Will Pay Out-of-Network (<u>OON</u>) <u>Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$10 <u>copay</u> per date of service	40% <u>coinsurance</u>	-----None-----
	<u>Specialist</u> visit	\$10 <u>copay</u> per date of service	40% <u>coinsurance</u>	Hearing exams are covered according to ACA guidelines.
	<u>Preventive care/screening/immunization</u>	No charge	0% <u>coinsurance</u>	One preventive exam and one mammogram per calendar year. Well-child care is covered to age 7. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	For a test in a provider's office or clinic, your cost is included in the cost-share listed above. \$10 copay per date of service on in-network diagnostic mammograms performed in an inpatient, outpatient or office setting. If an office visit and mammograms are done on the same day, a copay will be taken for the office visit and a separate copay for the mammogram. In-network independent labs for mental health/substance abuse services are not subject to coinsurance.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	For a test in a provider's office or clinic, your cost is included in the cost-share listed above.

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is at www.wellmark.com/prescriptions.</p>	Tier 1	\$10 <u>copay</u> per prescription	\$10 <u>copay</u> per prescription	<p>Drugs listed on Wellmark's Blue Rx Value Plus Drug List are covered. Drugs not on this Drug List are not covered. For out-of-network <u>prescription drugs</u>, you may be balance billed.</p> <p>1 <u>copay</u> for 30-day supply. 3 <u>copays</u> for 90-day supply (Retail maintenance). 2 <u>copays</u> for 90-day supply (Mail order maintenance). <u>Specialty drugs</u> are covered only when obtained through the CVS Specialty Pharmacy Program. <u>Copay</u> and <u>deductible</u> is waived for immunizations, including well-child immunizations under your drug card plan.</p> <p>Your <u>plan</u> includes coverage for certain <u>specialty drugs</u> through PrudentRx. If you choose to opt into the PrudentRx program, your <u>deductible</u> and <u>coinsurance</u> will be waived for drugs listed on the PrudentRx drug list. Information about the PrudentRx program can be found in your <u>plan</u> document in these sections: What You Pay, Details-Covered and Not Covered, Choosing a <u>Provider</u>, Factors Affecting What You Pay, and the Glossary. See wellmark.com/prescriptions for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your plan. Waive <u>deductible</u> and <u>copay</u> for immunizations including well-child immunizations under your drug card plan.</p>
	Tier 2	\$20 <u>copay</u> per prescription	\$20 <u>copay</u> per prescription	
	Tier 3	\$20 <u>copay</u> per prescription	\$20 <u>copay</u> per prescription	
	Specialty drugs	\$85 <u>copay</u> per prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	<u>Physician/surgeon fees</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay</u> per date of service for facility and physician(s) combined	\$200 <u>copay</u> per date of service for facility and physician(s) combined	For <u>emergency medical conditions</u> treated out-of-network, it is likely you may not be balance billed pursuant to the federal rules developed for implementation of the No Surprises Act.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	For covered non-emergent situations, out-of-network ground ambulance services are NOT reimbursed at the in-network level. The member may be balance billed for any out-of-network service as established under the rules developed for implementation of the No Surprises Act.
	<u>Urgent care</u>	\$10 <u>copay</u> per date of service for facility and physician(s) combined	40% <u>coinsurance</u>	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	<u>Physician/surgeon fees</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$10 <u>copay</u> per date of service Facility: 20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for <u>preventive services</u> . For any <u>in-network services</u> that fall outside of routine obstetric care, the office visit benefits shown above may apply.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Benefits shown reflect OB/GYN practitioner services which are typically globally billed at time of delivery for pre-natal, post-natal and delivery services.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	-----None-----
	<u>Home health care</u>	20% coinsurance	40% coinsurance	-----None-----
If you need help recovering or have other special health needs	<u>Rehabilitation services</u>	Office: \$10 copay per date of service Facility: 20% coinsurance	40% coinsurance	-----None-----
	<u>Habilitation services</u>	Office: \$10 copay per date of service Facility: 20% coinsurance	40% coinsurance	-----None-----
	<u>Skilled nursing care</u>	20% coinsurance	40% coinsurance	-----None-----
	<u>Durable medical equipment</u>	20% coinsurance	40% coinsurance	-----None-----
	<u>Hospice services</u>	20% coinsurance	40% coinsurance	-----None-----
If your child needs dental or eye care	Children's eye exam	No charge	0% coinsurance	One routine vision exam per calendar year.
	Children's glasses	Not covered	Not covered	-----None-----
	Children's dental check-up	Not covered	Not covered	-----None-----

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Custodial care - in home or facility
- Dental care - Adult
- Dental check-up
- Extended home skilled nursing
- Glasses
- Hearing aids
- Long-term care
- Routine foot care
- Some pharmacy drugs are not covered
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Applied Behavior Analysis therapy
- Bariatric surgery
- Chiropractic care
- Infertility treatment (\$25,000 LTM)
- Most coverage provided outside the U.S.
- Private-duty nursing -
 - short term intermittent home skilled nursing
 - Routine eye care - Adult (one vision exam per calendar year)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, you can contact: Wellmark at 1-800-524-9242.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

_____ To see examples of how this plan might cover costs for a sample medical situation, see the next page.

Wellmark Blue Cross and Blue Shield of Iowa is an independent licensee of the Blue Cross and Blue Shield Association.

This contains only a partial description of the benefits, limitations, exclusions and other provisions of the health care plan. It is not a contract or policy. It is a general overview only. It does not provide all the details of coverage, including benefits, exclusions, and policy limitations. In the event there are discrepancies between this document and the Coverage Manual, Certificate, or Policy, the terms and conditions of the Coverage Manual, Certificate, or Policy will govern.

About These Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$500
- PCP copayment \$10
- Hospital(facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost \$12,700

In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,010

Managing Joe's type 2 Diabetes (a years of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$500
- Specialist copayment \$10
- Hospital(facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost \$5,600

In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$920

Mia's Simple Fracture (in-network emergency room visit and follow up care)

- The plan's overall deductible \$500
- Specialist copayment \$10
- Hospital(facility) copayment \$200
- Other coinsurance 20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost \$2,800

In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$900

The amounts shown in the maternity claim example above are based on amounts using a single per person deductible. Some plans may actually apply a two-person or family deductible to maternity services for the mother and newborn baby.

The plan would be responsible for the other costs of these EXAMPLE covered services.



Wellmark Language Assistance

Discrimination is against the law

Wellmark Blue Cross and Blue Shield complies with applicable state and federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

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

You have the right to get this information and help in your language for free. If you need these services, call 800-524-9242.

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).

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

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)。

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 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).

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).

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

တၢ်ဒုးသ့ၣ်ညါ-န့ၣ်ကတိၢ်ကေညါကျိၣ်,ကျိၣ်တၢ်မၤစၢတၢ်ဖဲတၢ်မၤတဖၣ်,လၢတဘျီလၢတဘျီလၢဒုးသ့ၣ်,ဆိၣ်လၢန့ၣ်လိၤဆဲးကျိၣ်ဆူ ၈၀၀-၅၂၄-၉၂၄,၅၂၄တဖၣ်(TTY: ၈၈၈-၇၈၁-၄၂၆)တက့ၢ်.

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

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).

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

ສິ່ງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາ ໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ທີ່ຕໍ່ຕິ. (TTY: 888-781-4262.)

ማሰብያ: ከግርግር ለሚናገሩ ከሆነ፣ የቋንቋ አገዛ አገልግሎቶቻችን ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም በ(TTY: 888-781-4262) ደውሎ ያነጋግሩን።

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

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

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)।

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

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).

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': Diné k'éhjí yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Kojí' hółne' 800-524-9242 doodaii' (TTY: 888-781-4262)

Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Health Plan of Iowa, Inc. and Wellmark Blue Cross and Blue Shield of South Dakota are independent licensees of the Blue Cross and Blue Shield Association.




Glenwood CSD PPO Plan 2



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.wellmark.com or call 1-800-524-9242. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-524-9242 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$1,000 person/ \$2,000 family per calendar year.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Well-child care, in-network preventive care, routine vision exams, colonoscopy or sigmoidoscopy performed in the doctors office or outpatient facility, in-network independent labs, in-network prosthetic limbs and services subject to copayments are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. \$50 person/ \$100 family per calendar year for drug card, which does not apply to Tier 1 Rx. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Health: \$2,000 person/ \$4,000 family per calendar year. Drug Card: \$2,000 person/ \$4,000 family per calendar year. The In-Network health and drug card out-of-pocket maximum amounts accumulate together.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why this Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.wellmark.com or call 1-800-524-9242 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) <u>Provider</u> (You will pay the least)	What You Will Pay Out-of-Network (OON) <u>Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a <u>health care provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$15 <u>copay</u> per date of service	40% <u>coinsurance</u>	Primary Care Practitioners (PCP) are defined as General and Family Practice, Internal Medicine, OB/GYN, Pediatricians, Nurse Practitioners, Certified Nurse Midwives and PAs.
	<u>Specialist</u> visit	\$15 <u>copay</u> per date of service	40% <u>coinsurance</u>	Applies to Non-PCP providers. \$15 <u>copay</u> per date of service for in-network chiropractic services. Hearing exams are covered according to ACA guidelines.
	<u>Preventive care/screening/immunization</u>	No charge	40% <u>coinsurance</u>	One preventive exam and one gynecological exam per calendar year. One mammogram per calendar year. Well-child care is covered to age 7. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
<p>If you have a test</p>	<p><u>Diagnostic test</u> (x-ray, blood work)</p>	<p>20% <u>coinsurance</u></p>	<p>40% <u>coinsurance</u></p>	<p>For a test in a <u>provider's</u> office or clinic, your cost is included in the cost-share listed above. \$10 <u>copay</u> per date of service on <u>in-network</u> diagnostic mammograms performed in an inpatient, outpatient or office setting. If an office visit and mammograms are done on the same day, a <u>copay</u> will be taken for the office visit and a separate <u>copay</u> for the mammogram. <u>In-network</u> independent labs for mental health/substance abuse services are not subject to <u>coinsurance</u>.</p>
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is at www.wellmark.com/prescriptions.</p>	<p>Imaging (CT/PET scans, MRIs)</p> <p>Tier 1</p> <p>Tier 2</p> <p>Tier 3</p> <p>Specialty drugs</p>	<p>20% <u>coinsurance</u></p> <p>\$10 <u>copay</u> per prescription</p> <p>\$20 <u>copay</u> per prescription</p> <p>\$20 <u>copay</u> per prescription</p> <p>\$85 <u>copay</u> per prescription</p>	<p>40% <u>coinsurance</u></p> <p>\$10 <u>copay</u> per prescription</p> <p>\$20 <u>copay</u> per prescription</p> <p>\$20 <u>copay</u> per prescription</p> <p>Not covered</p>	<p>For a test in a <u>provider's</u> office or clinic, your cost is included in the cost-share listed above.</p> <p>Drugs listed on Wellmark's Blue Rx Value Plus Drug List are covered. Drugs not on this Drug List are not covered. For <u>out-of-network</u> <u>prescription drugs</u>, you may be balance billed.</p> <p>1 <u>copay</u> for 30-day supply.</p> <p>3 <u>copays</u> for 90-day supply (Retail maintenance).</p> <p>2 <u>copays</u> for 90-day supply (Mail order maintenance).</p> <p><u>Specialty drugs</u> are covered only when obtained through the CVS Specialty Pharmacy Program.</p> <p><u>Copay</u> and <u>deductible</u> is waived for immunizations, including well-child immunizations under your drug card plan.</p> <p>Your <u>plan</u> includes coverage for certain <u>specialty drugs</u> through PrudentRx. If you choose to opt into the PrudentRx program, your <u>deductible</u> and <u>coinsurance</u> will be waived for drugs listed on the PrudentRx drug list. Information about the PrudentRx program can be found in your <u>plan</u> document in these sections: What You Pay, Details-Covered and Not Covered, Choosing a <u>Provider</u>, Factors Affecting What You Pay, and the Glossary.</p> <p>See wellmark.com/prescriptions for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your plan.</p>

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None-----
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None-----
If you need immediate medical attention	Emergency room care	\$200 copay per date of service for facility and physician(s) combined	\$200 copay per date of service for facility and physician(s) combined	For emergency medical conditions treated out-of-network, it is likely you may not be balance billed pursuant to the federal rules developed for implementation of the No Surprises Act.
	Emergency medical transportation	20% coinsurance	20% coinsurance	For covered non-emergent situations, out-of-network ground ambulance services are NOT reimbursed at the in-network level. The member may be balance billed for any out-of-network service as established under the rules developed for implementation of the No Surprises Act.
	Urgent care	\$15 copay per date of service for facility and physician(s) combined	40% coinsurance	None-----
	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	None-----
If you have a hospital stay	Physician/surgeon fees	20% coinsurance	40% coinsurance	None-----
	Outpatient services	Office: \$15 copay per date of service Facility: 20% coinsurance	40% coinsurance	None-----
If you need mental health, behavioral health, or substance abuse services	Inpatient services	20% coinsurance	40% coinsurance	None-----

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for <u>preventive services</u> . For any <u>in-network services</u> that fall outside of routine obstetric care, the office visit benefits shown above may apply.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Benefits shown reflect OB/GYN practitioner services which are typically globally billed at time of delivery for pre-natal, post-natal and delivery services.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	-----None-----
	Home health care	20% coinsurance	40% coinsurance	-----None-----
	Rehabilitation services	Office: \$15 copay per date of service Facility: 20% coinsurance	40% coinsurance	-----None-----
If you need help recovering or have other special health needs	Habilitation services	Office: \$15 copay per date of service Facility: 20% coinsurance	40% coinsurance	-----None-----
	Skilled nursing care	20% coinsurance	40% coinsurance	-----None-----
	Durable medical equipment	20% coinsurance	40% coinsurance	-----None-----
	Hospice services	20% coinsurance	40% coinsurance	-----None-----
	Children's eye exam	No charge	0% coinsurance	One routine vision exam per calendar year.
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	-----None-----
	Children's dental check-up	Not covered	Not covered	-----None-----

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Custodial care - in home or facility
- Dental care - Adult
- Dental check-up
- Extended home skilled nursing
- Glasses
- Hearing aids
- Long-term care
- Routine foot care
- Some pharmacy drugs are not covered
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Applied Behavior Analysis therapy
- Bariatric surgery
- Chiropractic care
- Infertility treatment (\$25,000 LTM)
- Most coverage provided outside the U.S.
- Private-duty nursing -
 - short term intermittent home skilled nursing
 - Routine eye care - Adult (one vision exam per calendar year)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, you can contact: Wellmark at 1-800-524-9242.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

_____ To see examples of how this plan might cover costs for a sample medical situation, see the next page.

Wellmark Blue Cross and Blue Shield of Iowa is an independent licensee of the Blue Cross and Blue Shield Association.

This contains only a partial description of the benefits, limitations, exclusions and other provisions of the health care plan. It is not a contract or policy. It is a general overview only. It does not provide all the details of coverage, including benefits, exclusions, and policy limitations. In the event there are discrepancies between this document and the Coverage Manual, Certificate, or Policy, the terms and conditions of the Coverage Manual, Certificate, or Policy will govern.

About These Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$1,000
- PCP copayment \$15
- Hospital(facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$80
<u>Coinsurance</u>	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,040

Managing Joe's type 2 Diabetes (a years of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$1,000
- Specialist copayment \$15
- Hospital(facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$4,400
<u>Copayments</u>	\$900
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$4,920

Mia's Simple Fracture (in-network emergency room visit and follow up care)

- The plan's overall deductible \$1,000
- Specialist copayment \$15
- Hospital(facility) copayment \$200
- Other coinsurance 20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,340

The amounts shown in the maternity claim example above are based on amounts using a single per person deductible. Some plans may actually apply a two-person or family deductible to maternity services for the mother and newborn baby.

The plan would be responsible for the other costs of these EXAMPLE covered services.



Wellmark Language Assistance

Discrimination is against the law

Wellmark Blue Cross and Blue Shield complies with applicable state and federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

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

You have the right to get this information and help in your language for free. If you need these services, call 800-524-9242.

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).

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

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)。

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 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).

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).

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).

တၢ်ဒုးသ့ၣ်ညါ-န့ၣ်ကတိၢ်ကေညါကိၣ်, ကိၣ်တၢ်မၤစၢတၢ်ဖဲတၢ်မၤတဖၣ်, လၢတဘၣ်လၢတဘၣ်လၢ, ဆိၣ်လၢန့ၣ်လိၤဆဲးကိၣ်ဆူ ၈၀၀-၅၂၄-၉၂၄ န့ၣ်တဖၣ် (TTY: ၈၈၈-၇၈၁-၄၂၆) တက့ၢ်.

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

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).

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

ສິ່ງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ທີ່ຕໍ່ຕິ. (TTY: 888-781-4262.)

ማሰብያ: ከግርግር ለሚናገሩ ከሆነ፣ የቋንቋ አገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም (በTTY: 888-781-4262) ደውሎ ያነጋግሩ።

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

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

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)।

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

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).

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': Diné k'éhjí yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóíł. Kojí' hóíne' 800-524-9242 doodaii' (TTY: 888-781-4262)

Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Health Plan of Iowa, Inc. and Wellmark Blue Cross and Blue Shield of South Dakota are independent licensees of the Blue Cross and Blue Shield Association.



Glenwood CSD HDHP Plan 3



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.wellmark.com or call 1-800-524-9242. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-524-9242 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$3,500 person/\$7,000 family per calendar year.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Well-child care, routine vision exams and in-network preventive care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No. There are no other deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	\$3,500 person/\$7,000 family per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.wellmark.com or call 1-800-524-9242 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.



Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	Specialist visit	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Hearing exams are covered according to ACA guidelines.
	Preventive care/screening/immunization	No charge	0% <u>coinsurance</u>	One preventive exam and one mammogram per calendar year. Well-child care is covered to age 7. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	Imaging (CT/PET scans, MRIs)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is at www.wellmark.com/prescriptions.</p>	Tier 1	0% <u>coinsurance</u>	0% <u>coinsurance</u>	<p>Drugs listed on Wellmark's Blue Rx Value Plus Drug List are covered. Drugs not on this Drug List are not covered. You pay the discounted cost of your <u>prescription drugs</u> until your <u>in-network deductible</u> is met. For <u>out-of-network prescription drugs</u>, you may be balance billed.</p> <p>30-day supply for <u>prescription drugs</u>.</p> <p>90 day prescription maximum (maintenance).</p> <p><u>Specialty drugs</u> are covered only when obtained through the CVS Specialty Pharmacy Program.</p> <p><u>Deductible</u> is waived for immunizations, including well-child immunizations under your drug card plan.</p> <p>Your <u>plan</u> includes coverage for certain <u>specialty drugs</u> through PrudentRx. If you choose to opt into the PrudentRx program, your <u>coinsurance</u> will be waived for drugs listed on the PrudentRx drug list. Information about the PrudentRx program can be found in your <u>plan</u> document in these sections: What You Pay, Details-Covered and Not Covered, Choosing a <u>Provider</u>, Factors Affecting What You Pay, and the Glossary.</p> <p>See wellmark.com/prescriptions for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your plan.</p>
	Tier 2	0% <u>coinsurance</u>	0% <u>coinsurance</u>	
	Tier 3	0% <u>coinsurance</u>	0% <u>coinsurance</u>	
	Specialty drugs	0% <u>coinsurance</u>	Not covered	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	Physician/surgeon fees	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	<u>Emergency room care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	For <u>emergency medical conditions</u> treated out-of-network, it is likely you may not be balance billed pursuant to the federal rules developed for implementation of the No Surprises Act.
	<u>Emergency medical transportation</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	For covered non-emergent situations, out-of-network ground ambulance services are NOT reimbursed at the in-network level. The member may be balance billed for any out-of-network service as established under the rules developed for implementation of the No Surprises Act.
	<u>Urgent care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	Physician/surgeon fees	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	Inpatient services	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	Office visits	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for preventive services.
If you are pregnant	Childbirth/delivery professional services	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Benefits shown reflect OB/GYN practitioner services which are typically globally billed at time of delivery for pre-natal, post-natal and delivery services.
	Childbirth/delivery facility services	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	<u>Home health care</u>	0% coinsurance	0% coinsurance	-----None-----
	<u>Rehabilitation services</u>	0% coinsurance	0% coinsurance	-----None-----
	<u>Habilitation services</u>	0% coinsurance	0% coinsurance	-----None-----
	<u>Skilled nursing care</u>	0% coinsurance	0% coinsurance	-----None-----
	<u>Durable medical equipment</u>	0% coinsurance	0% coinsurance	-----None-----
	<u>Hospice services</u>	0% coinsurance	0% coinsurance	-----None-----
If your child needs dental or eye care	Children's eye exam	No charge	0% coinsurance	One routine vision exam per calendar year.
	Children's glasses	Not covered	Not covered	-----None-----
	Children's dental check-up	Not covered	Not covered	-----None-----

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Custodial care - in home or facility
- Dental care - Adult
- Dental check-up
- Extended home skilled nursing
- Glasses
- Hearing aids
- Long-term care
- Routine foot care
- Some pharmacy drugs are not covered
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Applied Behavior Analysis therapy
- Bariatric surgery
- Chiropractic care
- Infertility treatment (\$25,000 LTM)
- Most coverage provided outside the U.S.
- Private-duty nursing -
 - short term intermittent home skilled nursing
 - Routine eye care - Adult (One vision exam per calendar year)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cchio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, you can contact: Wellmark at 1-800-524-9242.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

_____ To see examples of how this plan might cover costs for a sample medical situation, see the next page.

Wellmark Blue Cross and Blue Shield of Iowa is an independent licensee of the Blue Cross and Blue Shield Association.

This contains only a partial description of the benefits, limitations, exclusions and other provisions of the health care plan. It is not a contract or policy. It is a general overview only. It does not provide all the details of coverage, including benefits, exclusions, and policy limitations. In the event there are discrepancies between this document and the Coverage Manual, Certificate, or Policy, the terms and conditions of the Coverage Manual, Certificate, or Policy will govern.

About These Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$3,500
- PCP coinsurance 0%
- Hospital(facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost \$12,700

In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$3,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,560

Managing Joe's type 2 Diabetes (a years of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$3,500
- Specialist coinsurance 0%
- Hospital(facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost \$5,600

In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$3,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$3,520

Mia's Simple Fracture (in-network emergency room visit and follow up care)

- The plan's overall deductible \$3,500
- Specialist coinsurance 0%
- Hospital(facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost \$2,800

In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

The amounts shown in the maternity claim example above are based on amounts using a single per person deductible. Some plans may actually apply a two-person or family deductible to maternity services for the mother and newborn baby.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Wellmark Language Assistance

Discrimination is against the law

Wellmark Blue Cross and Blue Shield complies with applicable state and federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

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

You have the right to get this information and help in your language for free. If you need these services, call 800-524-9242.

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).

ສິ່ງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາ ໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ທີ່ຕໍ່ຕິ. (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, नि:शुल्क 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 Deutsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei grieege. 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).

တၢ်ဒုးသုဂ်ညါ-န့ၢ်ကတိၢ်ကတိၢ်ကျိၢ်, ကျိၢ်တၢ်မၤစၢၤတၢ်ဖဲတၢ်မၤတဖၢၢ်, လၢတဘၣ်လၢတဘၣ်လၢ, ဆိၣ်လၢန့ၢ်လၢ, ဆဲးကျိၢ်ဆူ ၈၀၀-၅၂၄-၉၂၄, ၂၄၂၄၂၄ (TTY: ၈၈၈-၇၈၁-၄၂၆၂) တက့ၢ်.

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

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

ማሳሰቢያ: አማርኛ የሚናገሩ ስዊድን የቋንቋ አገዛ አገልግሎቶች: ከክፍያ ነፃ: ያገኛሉ:: በ 800-524-9242 ወይም (በTTY: 888-781-4262) ደውሎ ያነጋግሩ::

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

FUULEFFANNA: 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': Diné k'éhjí yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Kojí' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)

Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Health Plan of Iowa, Inc. and Wellmark Blue Cross and Blue Shield of South Dakota are independent licensees of the Blue Cross and Blue Shield Association.

IMPORTANT NOTICE FROM GLENWOOD COMMUNITY SCHOOL DISTRICT 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 Glenwood Community School District 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. Glenwood Community School District has determined that the prescription drug coverage offered by the Wellmark plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Glenwood CSD coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Glenwood CSD coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Glenwood CSD and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage,

your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice or Your Current Prescription Drug Coverage...

Contact the person listed below for further information 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 Glenwood CSD 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:	July 1, 2024
Name of Entity/Sender:	Glenwood Community School District
Contact--Position/Office:	Debbie Schoening, Admin Assistant
Address:	103 Central, Suite 300, Glenwood, IA 51534
Phone Number:	(712) 527-9034 ext. 1000

HIPAA SPECIAL ENROLLMENT NOTICE

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

Loss of Other Coverage (including Medicaid and State Child Health Coverage)

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

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

Marriage, Birth, or Adoption

If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption. Some plans may allow longer than 30 days, so please refer to your plan documents for your specific plan details.

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

Medicaid or State Child Health Coverage

If you or your dependents lose eligibility for coverage under Medicaid or State Child Health Coverage Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP or the determination of eligibility for a premium assistance subsidy.

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

WOMEN'S HEALTH & CANCER RIGHTS ACT OF 1998

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

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

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

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

NEWBORNS' AND MOTHER'S HEALTH PROTECTION ACT

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).

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Beginning in 2014, there is 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.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Each year, the open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the previous year. After Dec. 15, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent (as adjusted each year after 2014) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

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



Group Employee Application for Health Insurance

Wellmark Blue Cross and Blue Shield of Iowa and Wellmark Health Plan of Iowa, Inc. are independent licensees of the Blue Cross and Blue Shield Association.

Wellmark Blue Cross and Blue Shield of Iowa
updatesgroupmembership@wellmark.com

Failure to fill out this application completely may result in a delay of coverage.

Effective Date ____/____/____

Special Enrollee Change Open Enrollment Period Newly Eligible

A. Employer Information (Completed by Employer)

Employer Name _____
Employer Group Number _____
Employer Subgroup _____

B. Employee Information

Name (First, MI, Last) _____
Address Line 1 (Street Address or Suite#) _____
Address Line 2 (PO Box, Street Address) _____
City _____ State _____ ZIP _____
Home Phone Number (____) _____ Cell Phone Number (____) _____
Email Address _____

Date of Birth ____/____/____ (mm/dd/yyyy) Gender: Male Female Status: Single Married

Social Security Number/Tax Identification Number _____
(Social Security Number (SSN) or Tax Identification Number (TIN) must be provided.)

Date of Hire (required) ____/____/____ (mm/dd/yyyy)

Employment Status: Full-Time Part-Time COBRA Retiree Seasonal

Health: Employee Employee/spouse Employee/child(ren) Employee/spouse/child(ren)

Health Product ID* _____ Not Elected

*If you're enrolling in an HMO/WHPI plan a Primary Care Provider (PCP) must be elected for each family member. Please visit www.myWellmark.com to select your PCP.

As a Wellmark contract holder, you will receive a Summary of Benefits and Coverage (SBC) that outlines important information about your coverage. You can also access Wellmark.com/Inform to help you make the best decisions for you and your family. This site includes important information on your prescription drug coverage, like the accessibility and availability of prescription drugs, how to request a current drug list and the process for requesting an exception to the drug list. You also can find a list of participating providers and facilities, and how to obtain a prior authorization. For more information, or if you have any questions, you can call the Wellmark Customer Service number located on the back of your ID card.

C. Enrollment Reason or Event

Special Enrollment Event Reason:

- | | |
|---|--|
| <input type="checkbox"/> Birth | <input type="checkbox"/> Legal guardianship |
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Foster child placement |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Involuntary loss of creditable coverage |
| <input type="checkbox"/> Adoption or placement for adoption | <input type="checkbox"/> Permanent move to Iowa |
| <input type="checkbox"/> Court-ordered coverage | <input type="checkbox"/> Returning from military service |
| <input type="checkbox"/> Other _____ | |

List date of special enrollment event ____/____/____ (mm/dd/yyyy) (or last day of coverage)

Employee Name (First, Last)	Social Security Number / Tax Identification Number
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D. Members/enrollees Covered If you need to list more than four dependents, please write all necessary information on a separate sheet of paper and attach to this application. Your employer determines eligibility for coverage. Please confirm with your employer that the dependent types listed below are eligible.

Name (First, MI, Last)	Date of Birth (mm/dd/yyyy)	Social Security Number/Tax Identification Number ¹	Gender	FT Student? ²	Disabled? ²
<input type="checkbox"/> Spouse	/ /	a. <input type="checkbox"/> SSN/TIN _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	N/A	<input type="checkbox"/> Yes
<input type="checkbox"/> Dependent	/ /	a. <input type="checkbox"/> SSN/TIN _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> Dependent	/ /	a. <input type="checkbox"/> SSN/TIN _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> Dependent	/ /	a. <input type="checkbox"/> SSN/TIN _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> Dependent	/ /	a. <input type="checkbox"/> SSN/TIN _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

¹The IRS requires Wellmark to collect SSNs/TINs for federal reporting purposes. Your employer will follow up with you to collect this information if you do not complete a. or b. for each person listed. Failure to provide the SSN/TIN information may result in a monetary penalty, per violation, assessed to you by the IRS.

²If your plan covers dependent(s) age 26 or older, they must be unmarried and either a full-time student or a disabled dependent. Please contact your Wellmark representative for more information.

E. Medicare Coverage (Required)

Are you and/or anyone listed in the Dependent Information section Social Security disabled? Yes No
 Are you and/or anyone listed in the Dependent Information section enrolled in Medicare? **(Required if Medicare enrolled, absence of a response will be considered as a response of "No")** Yes No
 If yes, complete as appropriate:

Name ³	Medicare ID	Effective Dates		
		Part A	Part B	Part D
		/ /	/ /	/ /
		/ /	/ /	/ /

³If you need to list more than two members, please write all necessary information on a separate piece of paper and attach to this application.

Employee Name (First, Last)	Social Security Number / Tax Identification Number
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F. Other Health Coverage Information (Required)

Yes No Will you, your spouse, or your dependents keep other health coverage in addition to this Wellmark, Inc. coverage?
 If yes, please complete the following:
 Policyholder Name (First and Last) _____
 Please list those covered by the other health plan(s) _____
 Policy Number _____ Effective Date ____/____/____
 Insurance Company/HMO Name _____
 Is there a divorce decree/court order that requires one parent to provide health insurance coverage for any dependent?
 Yes No If yes, please complete the following:
 List dependent(s) _____
 List name of person required to provide health insurance _____
 List name of person who has primary physical custody _____

G. Important Information Regarding Waiver Enrollment

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 or 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 a period of time specified by your employer after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within the time specified by your employer after the marriage, birth, adoption, or placement for adoption. Additionally, you must enroll within the time specified by your employer after you lose eligibility for coverage under Medicaid or CHIP or become eligible for Medicaid or CHIP premium assistance.

Please note that if you or your dependents are not covered by minimum essential coverage, you may be responsible for individual shared responsibility payments when filing your federal income tax return. Also, by declining the coverage offered by your employer, you or your dependents may not be eligible for Marketplace coverage subsidies.

To request special enrollment or obtain more information, refer to your Summary Plan Description (SPD), coverage manual, other benefits documents, or contact your employer.

H. Authorization and Certification

I certify that I am legally authorized to apply for coverage for myself and all other persons named in this application. I understand that I am completing this application for the coverage sponsored by my employer or group sponsor and offered by Wellmark, Inc., doing business as Wellmark Blue Cross and Blue Shield of Iowa, or Wellmark Health Plan of Iowa, Inc. (each referenced herein as "Wellmark").

I certify that, after this application was completed, I carefully and fully read it, that the statements and answers set forth are full, true, and correct to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that my employer or group sponsor will rely on the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or concealed any material fact, my employer or group sponsor is entitled to declare the contracts applied for void and to refuse allowance on benefits to any person thereunder. I understand and grant authorization for my employer, group sponsor, consultant, or Wellmark agent to electronically submit the information provided by me on this signed application for enrollment purposes.

I acknowledge I have received or have been advised and understand I will receive from my employer the Summary of Benefits and Coverage (SBC).

Providing Social Security Numbers or Tax Identification Numbers
 Wellmark requires Social Security numbers or other tax identification numbers for federal reporting purposes. If Wellmark does not have Social Security or tax identification numbers for each enrollee, Wellmark or my employer may be unable to report and send information needed to complete federal tax returns. If Social Security numbers or tax identification numbers are not provided for all individuals covered, Wellmark or my employer may contact the primary policyholder to obtain the information. If I do not provide the Social Security numbers or tax identification numbers for these purposes, I may be subject to a monetary penalty imposed by the internal revenue service.

Employee Name (First, Last)	Social Security Number / Tax Identification Number
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H. Authorization and Certification, cont'd.

HSA Coverage

In the event I have selected a High Deductible Health Plan, I understand that enrolling in such coverage does not guarantee that I am or will be eligible to make contributions to an HSA or that contributions can be made to an HSA on my behalf.

Consent to Contact Me Via Residential Telephone, Cellular Phone, Text and Email Messages

By checking the box and entering my signature on this application, I hereby provide my consent to Wellmark to contact me about Wellmark policy or products and services that may be available to me. Wellmark may provide this information to me using residential telephone, cellular telephone or wireless device, text message or email contact information provided to Wellmark from time to time. If I provide a telephone number for voice calls, I understand that Wellmark may contact me via live or prerecorded calls. I give Wellmark permission to use my personal data (including personally identifiable information) in accordance with Wellmark's privacy policy to determine the types of products and services that may be offered to me. I understand the telephone company or other communications carrier may impose charges for these contacts and that I am not required to give this consent to purchase any goods or services. I understand I may revoke this consent at any time by calling the number located on the back of my Wellmark ID Card.

I understand that I have the right to refuse to sign this authorization, but that Wellmark will then have the right to condition eligibility determination and enrollment on the receipt of this signed authorization.

I authorize the Wellmark agent or agency who is identified with this application or my employer's group application to enter my application information through Wellmark's electronic enrollment process. In the event of any discrepancy between this paper application form and the information entered electronically may be considered the source of records, and I may contact Wellmark to make any changes to my enrollment information. Wellmark authorized agents are required to retain this original paper application for 11 years.

I have read and understand the Important Information Regarding Waiver of Enrollment and Authorization and Certification language on this application and acknowledge receipt of a fully completed copy of this application.

Employee Signature _____ Date ____/____/____

If applicant is a minor, please sign below.
Parent/Legal Guardian Printed Name: _____

Parent/Legal Guardian Signature: _____ Date ____/____/____

