GLENWOOD COMMUNITY SCHOOL DISTRICT

Certified and Classified Full-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.flmedicaidtplrecovery.com/flmedicaidtplrecovery.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.apsx** *KI-HIPP E-mail:* **KIHIPP.PROGRAM@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** **HHSHIPPProgram@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 RIte)
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

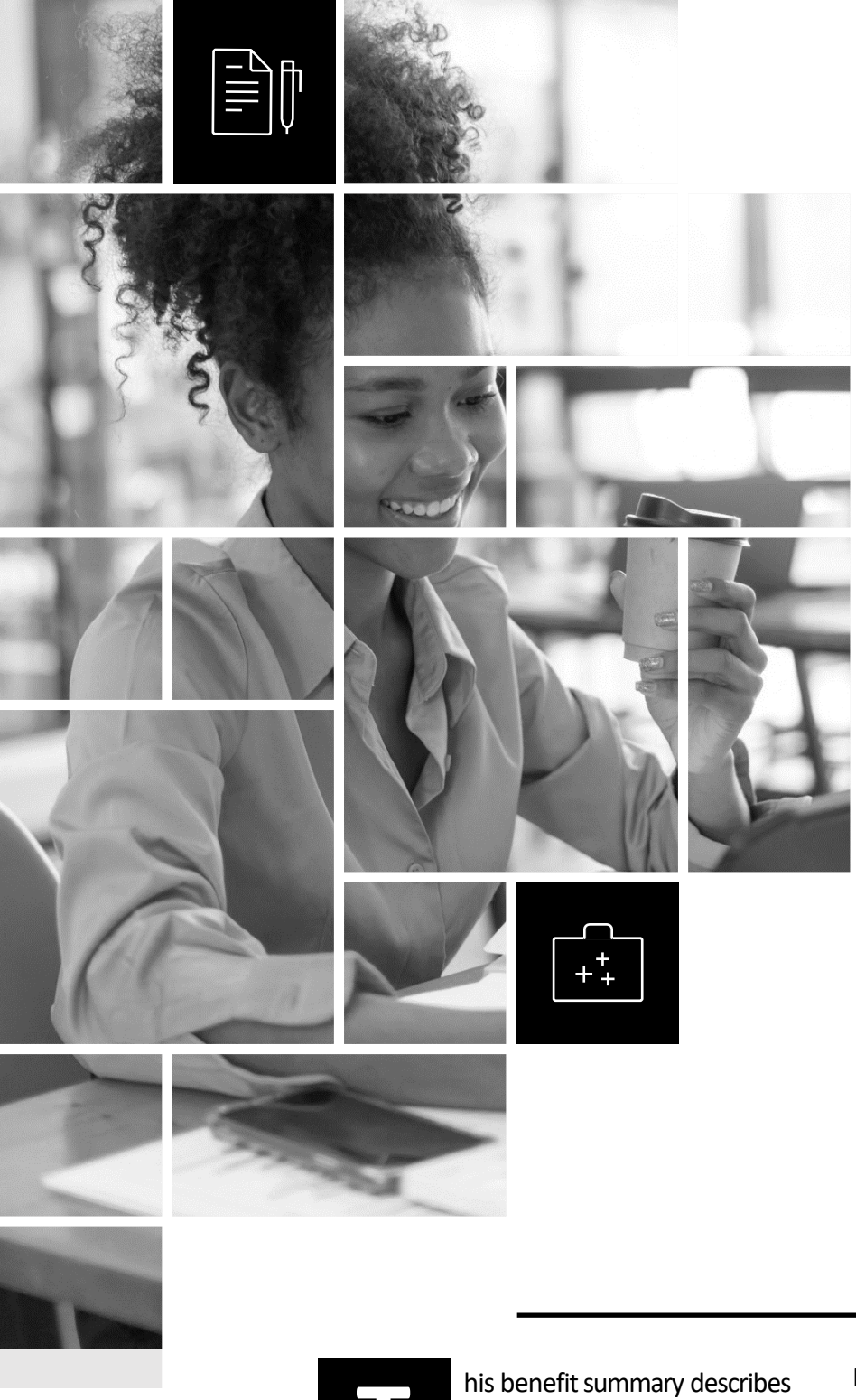


Table of Contents

This 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 Google Survey 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) Tier 1 Tier 2 Tier 3 Specialty	$50 Single/$100 Family $10 Copayment $20 Copayment $20 Copayment $85 Copayment	Not Covered
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) Tier 1 Tier 2 Tier 3 Specialty	$50 Single/$100 Family $10 Copayment $20 Copayment $20 Copayment $85 Copayment	Not Covered
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 **Tier 2** **Tier 3** **Specialty**	**Deductible, 0% Coinsurance**	**Not Covered**
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.**

dr. on demand by Included Health

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 treated for more than 80 common conditions including colds, flu, allergies and more.
- Get a prescription or short-term refill of any existing prescription sent to a pharmacy nearby, in less time than your usual doctor visit.
- 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.

Flexible Spending Account (FSA)

Tax-advantaged FSAs are a great way to save money. The money you contribute to these accounts comes out of your paycheck without being taxed, and you withdraw it tax-free when you pay for eligible health care and dependent care expenses.

Healthcare FSA

- Pay for eligible health care expenses, such as plan deductibles, copays, and coinsurance.
- Covers Medical, Dental, and Vision
- CANNOT contribute with an HSA

What are the contribution limits?

Employees can contribute up to **$3,200** for 2024. You can use the funds for any qualified medical, dental or vision expenses.

What happens at the end of the year?

FSAs are "Use It or Lose It" meaning if you do not spend your funds by the expense deadline, your funds will be forfeited.

The Health Care FSA allows for a 2.5 month extension of time, in which you may incur eligible expenses.

Dependent Care can only be reimbursed for expenses incurred in the plan year, July 1 through June 30.

Dependent Care FSA

Who can participate?

Any employee.

What are the contribution limits?

Employees can contribute up to **$5,000** annually per family or **$2,500** if filing separately.

What happens at the end of the year?

FSA funds expire at the end of each year. Use it or lose it. Unlike the healthcare FSA, your full election for the plan year is not available on the day your plan starts. For the dependent care FSA, you can only be reimbursed for qualified expenses up to the amount you have contributed to your FSA up to that point in time. As your contributions accrue, claims for reimbursement can be processed.

What's an Eligible Expense?

Health Care FSA – Plan deductibles, copays, coinsurance, and other health care expenses. To learn more, see IRS Publication 502 at www.irs.gov.

Dependent Care FSA – Child day care, babysitters, home care for dependent elders, and related expenses. To learn more, see IRS Publication 503 at www.irs.gov.

Dental Plan

In addition to protecting your smile, dental insurance helps pay for dental care and includes regular checkups, cleanings and x-rays. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.

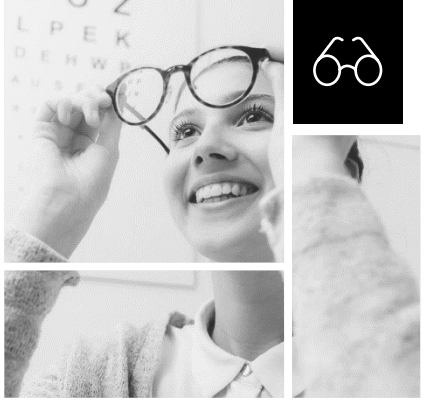
Dental coverage is offered for basic and major services. The dental plan also includes 100% coverage for preventive care. You and your eligible dependents may enroll in the dental coverage administered by **Delta Dental**.

Delta Dental	PPO	Premier / Out of Network
Annual Deductible – Individual	**$15**	**$25**
Annual Deductible – Family	**$45**	**$75**
Annual Maximum	**$1,000**	**$1,000**
Preventive Care	**Covered at 100%**	**Covered at 100%**
Basic Services	**10% after deductible**	**20% after deductible**
Major Services	**50% after deductible**	**50% after deductible**
Orthodontia Services	**50% after deductible Lifetime maximum $1,500**	**50% after deductible Lifetime maximum $1,500**

DELTA DENTAL®

Vision Plan

Your vision insurance is provided by **Avesis** and entitles you to specific eye care benefits. Our policy covers routine eye exams and other procedures, and provides specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses.



Avesis	In Network	Out Of Network
Office Visit		
Exam	Not Covered	Not Covered
Eyeglass Lenses Materials & Frames		
Single Vision Lenses	$10 Copay	Up to $25
Standard Lined Bifocal Lenses	$10 Copay	Up to $40
Standard Trifocal Lenses	$10 Copay	Up to $50
Lenticular	$10 Copay	Up to $80
Frames	$50 wholesale allowance up to $150 retail value	Up to $45
Elective Contacts	$130 Allowance	Up to $110
Medically Necessary Contacts	Covered in full	Up to $250
Frequency of Services		
Comprehensive Eye Exam	N/A	
Lenses or Contact Lenses	Once every 12 months	
Frames	Once every 24 months	

Life and AD&D Insurance

Basic Life and Accidental Death and Dismemberment (AD&D) Plan

The Basic Life and AD&D plan provides a benefit in the event of your death, dismemberment or paralysis. This benefit is sponsored by **Glenwood CSD**, so you will automatically be enrolled at no cost to you. Your coverage will be a lump sum amount of $50,000.

Beneficiary Information

To ensure your family's financial security, keep your beneficiary information up-to-date. Be sure to designate a beneficiary during open enrollment. You must choose at least one beneficiary; however, you can update or change your beneficiary at any time during the year. Please contact your Human Resources Department for any questions related to your beneficiary information.

Disability Coverage

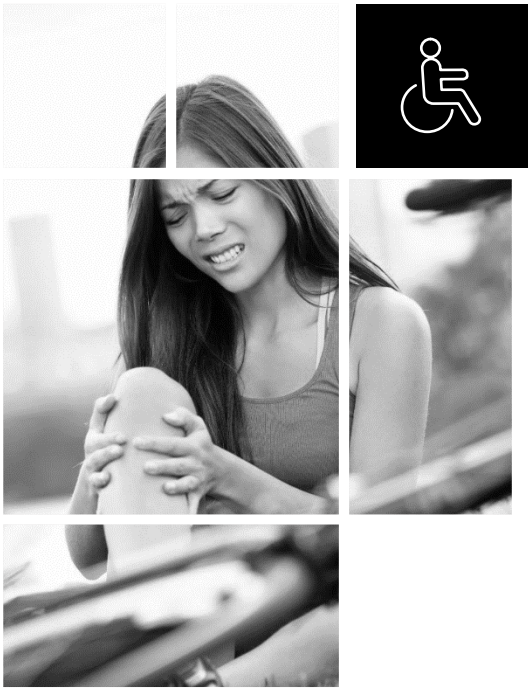
At Glenwood CSD, we want to do everything we can to protect you and your family. That's why Glenwood CSD pays for the full cost of long-term disability insurance—meaning that you owe nothing out of pocket.

In the event that you become disabled from a non-work-related injury or sickness, disability income benefits will provide a partial replacement of lost income.

Long-Term Disability Coverage (LTD)

If you are enrolled in the LTD plan , become disabled and out of work for 120 days or more, you may be eligible for an LTD benefit of up to 60% of total covered earnings up to a maximum benefit amount of $4,000.

This benefit continues until you recover or reach your Social Security normal retirement age, whichever is sooner.



MUTUAL of OMAHA

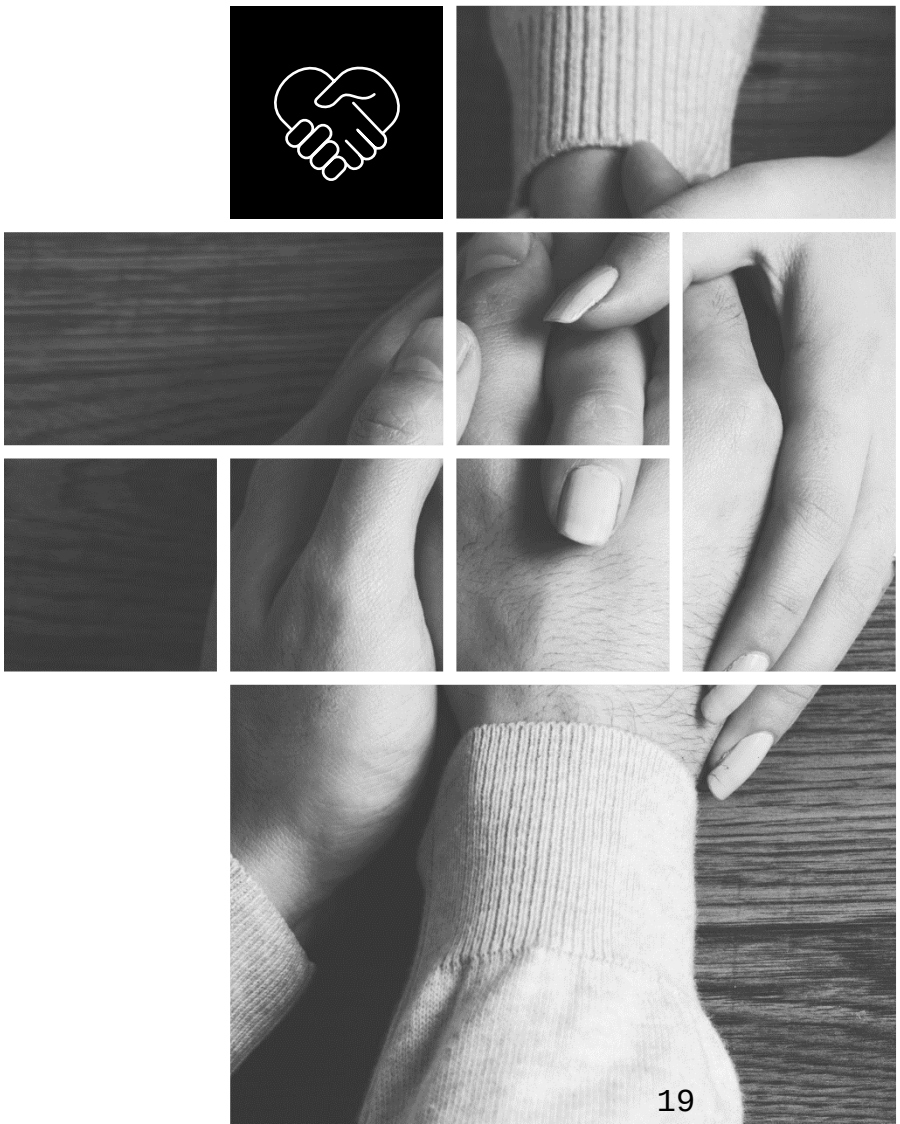
Employee Assistance Program

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**.

Best Care
EMPLOYEE ASSISTANCE PROGRAM



24 Hours A Day, 7 Days A Week

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

Voluntary Benefits

Accident Insurance

Accident insurance pays out a lump sum if you become injured because of an accident — even if the injuries you incur do not keep you out of work. While health insurance companies pay your provider or facility, Accident insurance pays you directly.

How Does Accident Insurance Work?

Accident insurance policies can provide you with a lump sum paid directly to you that will help pay for a wide range of situations, including initial care, surgery, transportation and lodging and follow-up care. Here's how it works:

- A set amount is payable based on the injury you suffer and the treatment you receive
- Benefits are payable directly to you (unless you specify otherwise) and can be used as you see fit
- Coverage is available for you, your spouse and eligible dependent children
- You do not need to answer medical questions or have a physical exam to get basic coverage
- Accident insurance covers injuries that happen on the job or off the job — unlike workers' compensation, which only covers on-the-job injuries
- Benefit payments are not reduced by any other insurance you may have with other companies

Covered expenses typically include:

- Emergency room visits
- Hospital stays
- Fractures and dislocations
- Medical exams
- Physical therapy
- Transportation and lodging

Critical Illness Insurance

While Medical insurance is vital, it doesn't cover everything. If you suffer from a serious illness, such as cancer, stroke or a heart attack, Medical insurance may not provide the coverage you need. Critical Illness insurance will ease the financial strain and help you focus on your recovery.

How Will a Critical Illness Claim Get Paid?

After purchasing Critical Illness insurance, if you suffer from one of the serious illnesses covered by your policy, you'll be paid in a lump sum. The payment will go directly to you instead of to a medical provider. The payment you receive can be used for many things including:

- Childcare costs
- Medical and living expenses
- Travel expenses for you and your family
- Lost wages from missed time at work

Covered Expenses Include:

- Heart attack
- Multiple Sclerosis
- Stroke
- Alzheimer's disease
- Parkinson's disease
- Major organ failure

Assurity

Please contact Debbie Schoening for additional details and rates.

How do I Enroll?

1. Review

Read through the information in this booklet.

2. Choose Your Plan

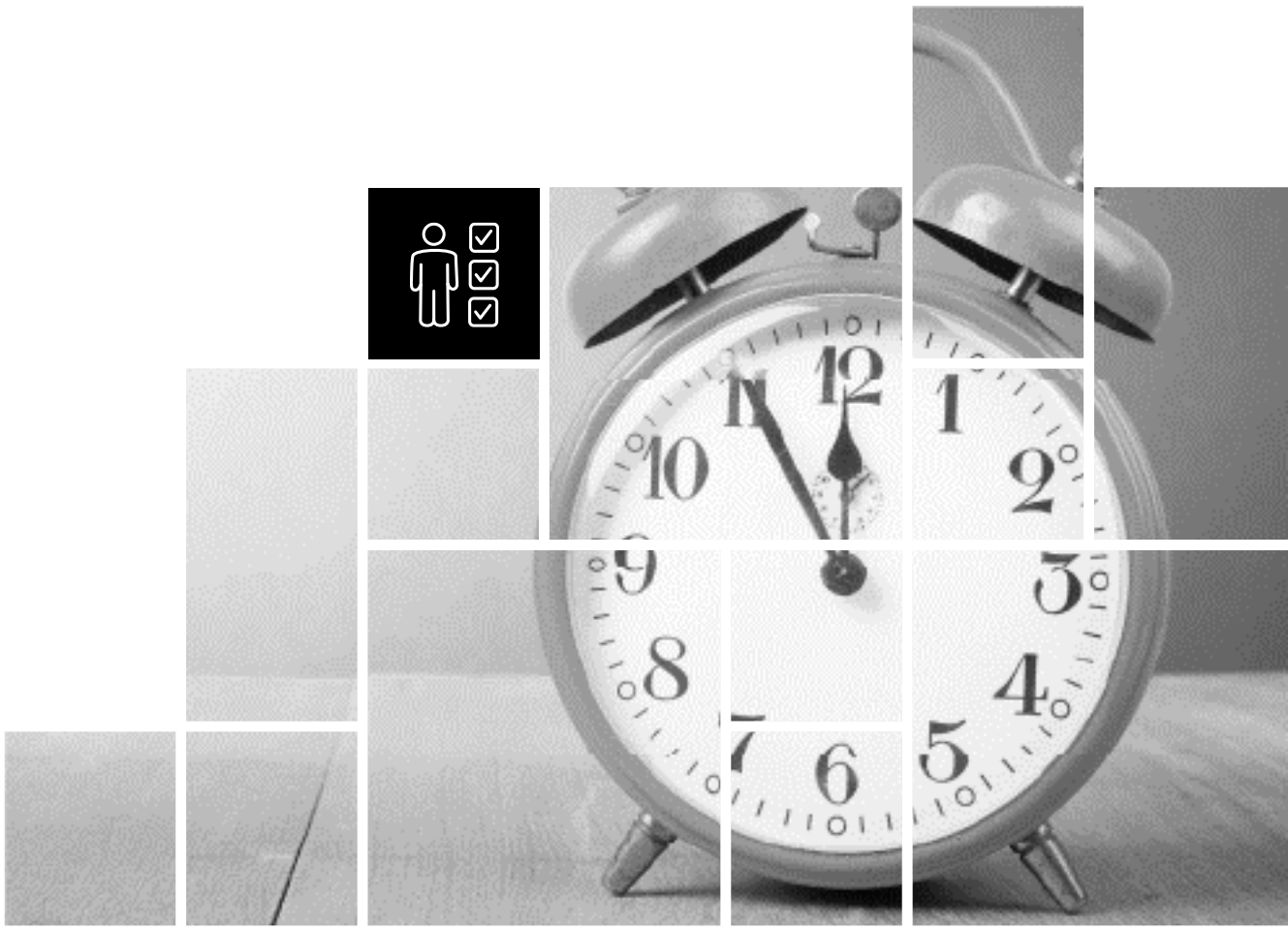
Utilize this booklet to help choose the lowest-cost, best-value health plan based on your medical needs.

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

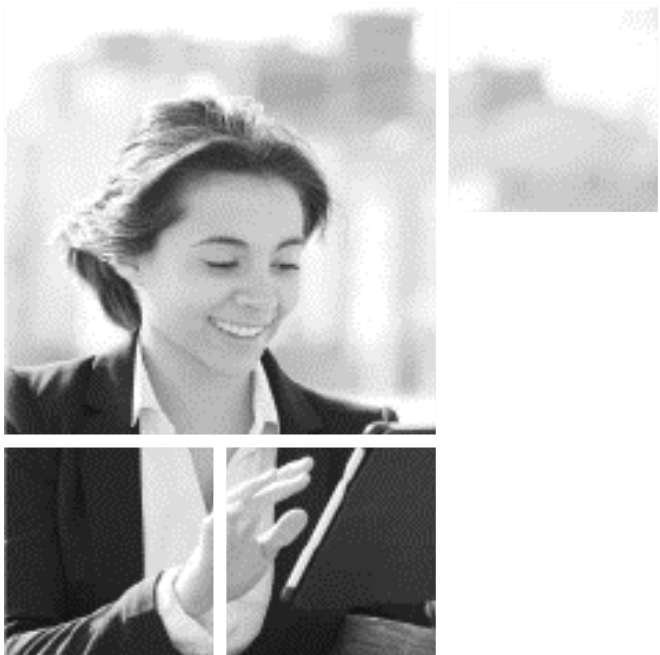
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

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
Dental	Delta Dental	800-544-0718	www.deltadentalia.com
Vision	Avesis	800-828-9341	www.avesis.com
Life and AD&D / Long Term Disability	Mutual of Omaha	800-369-3809	www.mutualofomaha.com
Flexible Spending Account	Health Equity	800-383-1623	www.healthequity.com
Health Savings Account	Health Equity	800-383-1623	www.healthequity.com
Accident / Critical Illness	Assurity	800-276-7619 (ext. 4210)	www.assurity.com
Employee Assistance Program	Best Care	800-666-8606	www.bestcareEAP.org
Human Resources	Debbie Schoening	712-527-9034 (ext. 1000)	schoeningd@glenwoodschools.org
Holmes Murphy Contact	Amanda Bellville	515-223-6825	ABellville@holmesmurphy.com
Holmes Murphy Contact	Nikki Endicott	515-223-6864	NEndicott@holmesmurphy.com

Wellmark

Coverage Period: 07/01/2024 – 06/30/2025
Coverage for: Single & Family | Plan Type: PPO

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 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	$10 copay per date of service	40% coinsurance	------None------
	Specialist visit	$10 copay per date of service	40% coinsurance	Hearing exams are covered according to ACA guidelines.
	Preventive care/screening/ immunization	No charge	0% coinsurance	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.

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
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is at www.wellmark.com/prescriptions.	Tier 1	$10 copay per prescription	$10 copay per prescription	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 prescription drugs, you may be balance billed. 1 copay for 30-day supply. 3 copays for 90-day supply (Retail maintenance). 2 copays for 90-day supply (Mail order maintenance). Specialty drugs are covered only when obtained through the CVS Specialty Pharmacy Program. Copay and deductible is waived for immunizations, including well-child immunizations under your drug card plan. Your plan includes coverage for certain specialty drugs through PrudentRx. If you choose to opt into the PrudentRx program, your deductible and coinsurance will be waived for drugs listed on the PrudentRx drug list. Information about the PrudentRx program can be found in your plan document in these sections: What You Pay, Details-Covered and Not Covered, Choosing a Provider, 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 deductible and copay for immunizations including well-child immunizations under your drug card plan.
	Tier 2	$20 copay per prescription	$20 copay per prescription	
	Tier 3	$20 copay per prescription	$20 copay per prescription	
	Specialty drugs	$85 copay per prescription	Not covered	
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------

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	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	$10 copay per date of service for facility and physician(s) combined	40% coinsurance	------None------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	------None------
	Physician/surgeon fees	20% coinsurance	40% coinsurance	------None------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $10 copay per date of service Facility: 20% coinsurance	40% coinsurance	------None------
	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 preventive services. For any in-network services 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------
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	------None------
	Rehabilitation services	Office: $10 copay per date of service Facility: 20% coinsurance	40% coinsurance	------None------
	Habilitation services	Office: $10 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------
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.cciio.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.

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	
Deductibles	$500
Copayments	$50
Coinsurance	$400
What isn't covered	
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	
Deductibles	$100
Copayments	$800
Coinsurance	$0
What isn't covered	
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	
Deductibles	$500
Copayments	$300
Coinsurance	$100
What isn't covered	
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).

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).

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

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

ध्यान रखें : अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, 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 Deitsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

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

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

တၢ်နှးသ့ဉ်ညါ–နမ့ၢ်ကတိၤကညီကျိာ်.ကျိာ်တၢ်မၤစၢၤတၢ်ဖံးတၢ်မၤတဖဉ်.လၢတဘဉ်လာ်ဘူးလဲ.ဆိဉ်လၢနဂီၢ်လီၤ.ဆဲးကျိုးဆူ ၈၀၀–၅၂၄–၉၂၄၂မ့တမ့ၢ်(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 ከሆነ፣ የቋንቋ እገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም (በTTY: 888-781-4262) ይሙላው ያነጋግሩን።

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

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

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

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

M-2318376 02/21 A

Wellmark

Coverage Period: 07/01/2024 – 06/30/2025
Coverage for: Single & Family | Plan Type: PPO

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.

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Important Questions	Answers	Why this Matters:
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	$15 copay per date of service	40% coinsurance	Primary Care Practitioners (PCP) are defined as General and Family Practice, Internal Medicine, OB/GYN, Pediatricians, Nurse Practitioners, Certified Nurse Midwives and PAs.
	Specialist visit	$15 copay per date of service	40% coinsurance	Applies to Non-PCP providers. $15 copay per date of service for in-network chiropractic services. Hearing exams are covered according to ACA guidelines.
	Preventive care/screening/ immunization	No charge	40% coinsurance	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 provider if the services needed are preventive. Then check what your plan 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.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is at www.wellmark.com/prescriptions.	Tier 1	$10 copay per prescription	$10 copay per prescription	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 prescription drugs, you may be balance billed. 1 copay for 30-day supply. 3 copays for 90-day supply (Retail maintenance). 2 copays for 90-day supply (Mail order maintenance). Specialty drugs are covered only when obtained through the CVS Specialty Pharmacy Program. Copay and deductible is waived for immunizations, including well-child immunizations under your drug card plan. Your plan includes coverage for certain specialty drugs through PrudentRx. If you choose to opt into the PrudentRx program, your deductible and coinsurance will be waived for drugs listed on the PrudentRx drug list. Information about the PrudentRx program can be found in your plan document in these sections: What You Pay, Details-Covered and Not Covered, Choosing a Provider, 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.
	Tier 2	$20 copay per prescription	$20 copay per prescription	
	Tier 3	$20 copay per prescription	$20 copay per prescription	
	Specialty drugs	$85 copay per prescription	Not covered	

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------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	------None------
	Physician/surgeon fees	20% coinsurance	40% coinsurance	------None------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $15 copay per date of service Facility: 20% coinsurance	40% coinsurance	------None------
	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 preventive services. For any in-network services 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------
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	------None------
	Rehabilitation services	Office: $15 copay per date of service Facility: 20% coinsurance	40% coinsurance	------None------
	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------
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.cciio.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.

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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$80
Coinsurance	$900
What isn't covered	
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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$4,400
Copayments	$900
Coinsurance	$0
What isn't covered	
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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$300
Coinsurance	$40
What isn't covered	
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).

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).

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

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

ध्यान रखें : अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, 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 Deitsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

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

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

တ၀်ဒုးသ့ဉ်ညါ–နမ့်ကတိၤကညီကျိာ်.ကျိာ်တ၀်မၤစၢၤတ၀်ဖံးတ၀်မၤတဖဉ်.လၢတဘဉ်လာ်ဘူးလဲ.ဆိဉ်လၢနဂီၢ်လီၤ.ဆဲးကျိုးဆူ ၈၀၀–၅၂၄–၉၂၄၂မ့တမ့ာ်(TTY:၈၈၈–၇၈၁–၄၂၆၂)တက့ာ်.

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

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

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

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

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

M-2318376 02/21 A

Wellmark

Coverage Period: 07/01/2024 – 06/30/2025
Coverage for: Single & Family | Plan Type: PPO HDHP

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.

04/09/2024;07/01/2024;PL002498;RL004041;384244-9;304839-65;00002045;N;NGF

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% coinsurance	0% coinsurance	------None------
	Specialist visit	0% coinsurance	0% coinsurance	Hearing exams are covered according to ACA guidelines.
	Preventive care/screening/ immunization	No charge	0% coinsurance	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% coinsurance	0% coinsurance	------None------
	Imaging (CT/PET scans, MRIs)	0% coinsurance	0% 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 need drugs to treat your illness or condition More information about **prescription drug coverage** is at www.wellmark.com/prescriptions.	Tier 1	0% coinsurance	0% coinsurance	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 prescription drugs until your in-network deductible is met. For out-of-network prescription drugs, you may be balance billed. 30-day supply for prescription drugs. 90 day prescription maximum (maintenance). Specialty drugs are covered only when obtained through the CVS Specialty Pharmacy Program. Deductible is waived for immunizations, including well-child immunizations under your drug card plan. Your plan includes coverage for certain specialty drugs through PrudentRx. If you choose to opt into the PrudentRx program, your coinsurance will be waived for drugs listed on the PrudentRx drug list. Information about the PrudentRx program can be found in your plan document in these sections: What You Pay, Details-Covered and Not Covered, Choosing a Provider, 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.
	Tier 2	0% coinsurance	0% coinsurance	
	Tier 3	0% coinsurance	0% coinsurance	
	Specialty drugs	0% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	0% coinsurance	------None------
	Physician/surgeon fees	0% coinsurance	0% 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 need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	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	0% coinsurance	0% 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	0% coinsurance	0% coinsurance	------None------
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	0% coinsurance	------None------
	Physician/surgeon fees	0% coinsurance	0% coinsurance	------None------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	0% coinsurance	------None------
	Inpatient services	0% coinsurance	0% coinsurance	------None------
If you are pregnant	Office visits	0% coinsurance	0% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	0% coinsurance	0% 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	0% coinsurance	0% 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 need help recovering or have other special health needs	Home health care	0% coinsurance	0% coinsurance	------None------
	Rehabilitation services	0% coinsurance	0% coinsurance	------None------
	Habilitation services	0% coinsurance	0% coinsurance	------None------
	Skilled nursing care	0% coinsurance	0% coinsurance	------None------
	Durable medical equipment	0% coinsurance	0% coinsurance	------None------
	Hospice services	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.cciio.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.

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	
Deductibles	$3,500
Copayments	$0
Coinsurance	$0
What isn't covered	
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	
Deductibles	$3,500
Copayments	$0
Coinsurance	$0
What isn't covered	
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	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
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).

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

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

ध्यान रखें : अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, 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 Deitsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

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

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

တၢ်နှးသ့ဉ်ညါ–နမ့ၢ်ကတိၤကညီကျိာ်.ကျိာ်တၢ်မၤစၢၤတၢ်ဖံးတၢ်မၤတဖဉ်.လၢတဘဉ်လာ်ဘူးလဲ.ဆိဉ်လၢနဂီၢ်လီၤ.ဆဲးကျိုးဆူ ၈၀၀–၅၂၄–၉၂၄၂မ့တမ့ၢ်(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 ከሆነ፣ የቋንቋ እገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም (በTTY: 888-781-4262) ይሙላው ያነጋግሩን።

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

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

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

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

M-2318376 02/21 A

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.

Wellmark

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.

Group Employee Application for Health Insurance

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:

☐ Birth
☐ Marriage
☐ Divorce
☐ Adoption or placement for adoption
☐ Court-ordered coverage
☐ Other _____
☐ Legal guardianship
☐ Foster child placement
☐ Involuntary loss of creditable coverage
☐ Permanent move to Iowa
☐ Returning from military service

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

Employee Name (First, Last)	Social Security Number / Tax Identification Number

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]
☐ Spouse		/ /	a. ☐ SSN/TIN ____ b. ☐ Does not have an SSN/TIN	☐ Male ☐ Female	N/A	☐ Yes
☐ Dependent		/ /	a. ☐ SSN/TIN ____ b. ☐ Does not have an SSN/TIN	☐ Male ☐ Female	☐ Yes	☐ Yes
☐ Dependent		/ /	a. ☐ SSN/TIN ____ b. ☐ Does not have an SSN/TIN	☐ Male ☐ Female	☐ Yes	☐ Yes
☐ Dependent		/ /	a. ☐ SSN/TIN ____ b. ☐ Does not have an SSN/TIN	☐ Male ☐ Female	☐ Yes	☐ Yes
☐ Dependent		/ /	a. ☐ SSN/TIN ____ b. ☐ Does not have an SSN/TIN	☐ Male ☐ Female	☐ Yes	☐ Yes

[1]The 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.

[2]If 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
		/ /	/ /	/ /
		/ /	/ /	/ /

[3]If 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

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

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** _____/_____/_____

DELTA DENTAL

Large Employer Group Enrollment/Change Form

☐ New Applicant ☐ Change of Coverage ☐ Name/Address Change

Employer Choice

(Completed by Employer)

Group Number _____ **Effective Date** ___/___/___ **Department/EE Number** _____

1 POLICYHOLDER INFORMATION

Name (First, Middle Initial, Last) _____ **Social Security Number** _____

Mailing Address _____ **City** _____ **State** _____ **Zip** _____

Status ☐ Single ☐ Married ☐ Other (specify) _____ **Hire Date** ___/___/___

Telephone (_____)_____ ☐ Home ☐ Cell Phone **Email Address** _____

Employer Name _____ **Employer Location** _____

2 ELIGIBLE MEMBERS ELECTING COVERAGE

List self & eligible members to be covered First Name MI Last (if different)	Social Security Number	Birthdate	Sex	Full-Time College Student	Disabled Status	Other Dental Coverage
Self		___/___/____	☐ M ☐ F		☐ Yes ☐ No	☐ No ☐ Yes
Spouse		___/___/____	☐ M ☐ F		☐ Yes ☐ No	☐ No ☐ Yes
Eligible Child		___/___/____	☐ M ☐ F	☐ Yes ☐ No School Name:	☐ Yes ☐ No	☐ No ☐ Yes
Eligible Child		___/___/____	☐ M ☐ F	☐ Yes ☐ No School Name:	☐ Yes ☐ No	☐ No ☐ Yes
Eligible Child		___/___/____	☐ M ☐ F	☐ Yes ☐ No School Name:	☐ Yes ☐ No	☐ No ☐ Yes

Other Dental Coverage – if any person(s) on this application has other dental insurance please complete.

Policyholder _____

Name of Other Dental Carrier(s) _____ Policy Number _____ Effective Date ___/___/___ Contract Type ☐ **Single** ☐ **Family**

3 CHANGE OF COVERAGE

Please check events requiring Contract changes:

☐ **Marriage** ☐ **Death** ☐ **Divorce** ☐ **Birth/Adoption** ☐ **Drop Covered Person** ☐ **COBRA** ☐ **Terminating Benefits** ☐ **Part-Time to Full-Time**

☐ **Other** (explain) _____ Name of Affected Party _____ Date of Event ___/___/___

4 AGREEMENT AND CERTIFICATION

I have read and understand the Agreement and Certification and/or Waiver of Coverage language on the back of this application and acknowledge receipt of a fully completed copy of this application.

ACCEPTANCE/WAIVER OF COVERAGE

☐ I accept the dental coverage selected above.

☐ I waive dental coverage for my family members and/or myself. (Please indicate reason) _____

X _____ ___/___/___

Employee Signature Date

AGREEMENT AND CERTIFICATION

I certify I am legally authorized to apply for coverage for myself and/or for all other persons named in this application. I understand I am applying for coverage sponsored by my employer or Plan Sponsor offered by Delta Dental of Iowa ("Delta Dental"). I authorize my employer, to deduct from my pay or collect from me in advance the premium therefore and remit such sums to Delta Dental on my behalf. This authorization is to remain in effect until I, or my employer or Plan Sponsor, notifies Delta Dental to the contrary. I understand coverage for the dental policy applied for will not start until after this application and the monies for the first month's premium are deducted from my pay or paid to my employer, and are received and accepted by Delta Dental. I further understand that Delta Dental establishes the effective date of the policy. I also understand the amounts are subject to change at least annually and my employer or Plan Sponsor will furnish written notice of such changes to me.

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 Delta Dental will rely upon 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 have concealed any material fact, Delta Dental will be entitled to declare the dental and/or vision policy applied for void and refuse allowance of benefits to any person thereunder.

I authorize any health care provider to release medical records to Delta Dental when reasonably related to the dental coverage for which I have applied for. If any law or regulation requires additional authorization for release of dental and/or vision records, I will give this authorization.

WAIVER OF COVERAGE

I understand if I decide not to apply for coverage, or if I apply only for myself even though coverage is available for eligible members of my family, any subsequent application will be subject to the applicable terms and conditions of the Group Insurance Policy to provide dental benefits, which may require additional limitations and waiting periods. I also understand Delta Dental reserves the right to reject such an application.

NONDISCRIMINATION AND ACCESSIBILITY

Delta Dental of Iowa complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. To review our full non-discrimination notice, please go to www.deltadentalia.com/nondiscrimination.

2644-A10037 06/2021

avēsis

Glenwood Community School District
60790-36
050130KZ

☐ I am Waiving Vision Insurance

AVĒSIS ADVANTAGE VISION CARE EMPLOYEE ENROLLMENT FORM

PLEASE PRINT LEGIBLY

Underwritten by Fidelity Security Life Insurance Company® Kansas City, Missouri

Policy No. VC-16

TO BE COMPLETED BY THE EMPLOYEE

Employee Last Name	*Employee First Name*	*MI*

Date of Birth / /	*Social Security Number* - -	*Sex* ☐ Male ☐ Female

Street Address	*Apartment No.*

City	*State*	*Zip Code* -

Do you wish to cover your eligible dependents? ☐ Yes ☐ No

If yes, complete the following:

	Dependent Name	*Date of Birth*
Spouse/Domestic Partner		/ /
Child		/ /
Child		/ /
Child		/ /
Child		/ /
Child		/ /
Child		/ /

☐ ***I would like to cover additional eligible dependents*** (PLEASE LIST ON A SECOND ENROLLMENT FORM)

By signing below, I agree to receive all documents and correspondence electronically and that I can access the internet or the email address provided. I understand that I may revoke this authorization or request specific paper documents without revoking this authorization by contacting the Company {or Administrator} by mail, email, or telephone.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I authorize deductions from my earnings at the required contributions towards the cost of the coverage.

Signature	*Date* / /

TO BE COMPLETED BY THE EMPLOYER

☐ **New Enrollment**	☐ **Add** ☐ Dependents	☐ **Change** ☐ Address ☐ Name ☐ Phone ☐ COBRA	☐ **Cancel Coverage** ☐ Policy Holder ☐ Dependent(s)
Reason for Change	☐ Employment Status ☐ Qualifying Event: (PLEASE STATE) _____		
Requested Effective Date / /		*Date of Employment* / /	

A-00713
M-9059/M-9069/M-9086

REV 6/22

Enrollment Form
United of Omaha Life Insurance Company

3300 Mutual of Omaha Plaza, Omaha, Nebraska 68175

Employer Section (To be completed by the employer. Required fields are marked with an asterisk(*).)

*Employer Name: Glenwood Community School District		Effective Date:	Group ID: G000CH6B
Sub Group ID:	Location Code:	Class:	Occupation:
*Salary: ☐ Hourly ☐ Weekly ☐ Bi-Weekly $ ☐ Monthly ☐ Semi-Monthly ☐ Annually		*Date of Hire:	Hours Worked Per Week:

Employee Section (Please print clearly. Required fields are marked with an asterisk(*).)

*Last Name:	*First Name:		MI:
*SSN/ID Number:	*Birth Date (MM/DD/YYYY):	*Gender:	*Marital Status:
*Street Address:		E-mail Address:	
*City:	*State:	*Zip Code:	Telephone: ( ) -

Long-Term Disability Coverage Election

Employee Coverage Only	Enroll	Decline	Benefit Amount	Premium Amount
Long-Term Disability	☒	☐	_____ per Month	Paid by Employer

Basic Life and AD&D Coverage Election

Employee Coverage Only	Enroll	Decline	Benefit Amount	Premium Amount
Basic Life and AD&D - Employee	☒	☐	_____	Paid by Employer

Beneficiary for Death Benefits (Right to change beneficiary is reserved to the insured.)

If naming more than one beneficiary, please attach a separate signed and dated sheet. Beneficiaries shall share benefits equally unless otherwise stated. Some states have laws regarding beneficiary designation. Please consult your employer/benefits administrator for additional information.

Primary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	SSN
Telephone:	Address of Beneficiary (Address, City, State, Zip):			

Secondary Beneficiary Designation

Last Name	First Name	Relationship to Insured	Date of Birth (MM/DD/YYYY)	SSN
Telephone:	Address of Beneficiary (Address, City, State, Zip):			

Enrollment Information

Enrollment must occur within 31 days from the date the employee becomes eligible (or as otherwise stated in the applicable policy). If you are required to pay premiums for any coverage, the enrollment form **MUST** be signed and dated to authorize payroll deductions. The premium amounts indicated on this form are estimates, and are subject to change based on the final terms and conditions of the applicable policy as well as your age and/or salary on the effective date of the coverage.

Agreement and Signature

I represent that the information I have provided in this enrollment form is complete, true and accurate to the best of my knowledge. I understand that payment of premium does not guarantee eligibility for coverage. I understand and agree that I must satisfy all active work or active eligibility requirements that pertain to the policy to be eligible for coverage.

Should I apply for waived coverage in the future, I understand that evidence of insurability may be required, acceptable to the underwriting company, **at my own expense**. I understand that if coverage is applied for in the future, it must be during an enrollment period approved by the underwriting company or due to a life change event as defined or allowed by the applicable policy, and that a waiting period may apply.

By signing below, I acknowledge that I understand and agree to the above statements, and that I have read and understand the benefit summary or outline of coverage provided to me for each type of coverage. The above requirements will apply unless otherwise stated in the applicable policy, or unless prohibited by any applicable state or federal law.

SIGNATURE OF EMPLOYEE _____ **DATE** _____/_____/_____

Additional Information

Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. *(Note: This fraud warning does not apply to residents of AL, AR, CA, CO, DC, FL, KS, KY, LA, ME, MD, NJ, NM, NY, OH, OR, PR, RI, TN, VT and VA. Please review the specific fraud warning for your state of residence if provided below, or view it online at www.mutualofomaha.com.)*

Assurity®

Assurity® Life Insurance Company
Post Office Box 82533, Lincoln, NE 68501-2533
402-476-6500 | 800-276-7619 | FAX 877-864-6630

GROUP PARTICIPANT ENROLLMENT FORM

PLEASE PRINT WITH BLACK INK

☐ **New Enrollee**
☐ **Coverage Change**

Group Name: Glenwood Community School District

Location: _____

Requested Issue Date: (MM/DD/YYYY) / /

A. Participant Information

Applicant's Legal Name (First, Middle, Last)			Date of Birth (MM/DD/YYYY) / /
Applicant's Mailing Address (Street Address)	(City)	(State)	(ZIP+4)
Applicant's Email Address			Personal Phone Number ( )
☐ Male ☐ Female	Social Security No.	Birth State/Country	
Date of Employment (MM/DD/YYYY) / /	Hours per week	Annual Salary $	

Are you employed at least 20 hours per week, working your normally scheduled hours and able to perform the regular duties of your job? ☐ Yes ☐ No

If NO, please explain.

During the past **12 months**, has any Proposed Insured used any form of tobacco or nicotine-based products or substitutes such as patches or gum?

Applicant ..... ☐ Yes ☐ No
Spouse ..... ☐ Yes ☐ No

SPOUSE INFORMATION:

Spouse's Legal Name (First, Middle, Last)			Date of Birth (MM/DD/YYYY) / /
☐ Male ☐ Female	Social Security No.	Birth State/Country	

CHILD INFORMATION: If additional space is needed, please attach a separate sheet of paper.

Child's Legal Name (First, Middle, Last)	Relationship to Applicant	☐ Male ☐ Female	Date of Birth (MM/DD/YYYY) / /
Child's Legal Name (First, Middle, Last)	Relationship to Applicant	☐ Male ☐ Female	Date of Birth (MM/DD/YYYY) / /
Child's Legal Name (First, Middle, Last)	Relationship to Applicant	☐ Male ☐ Female	Date of Birth (MM/DD/YYYY) / /
Child's Legal Name (First, Middle, Last)	Relationship to Applicant	☐ Male ☐ Female	Date of Birth (MM/DD/YYYY) / /

B. Voluntary Benefit Election — Completion of a Statement of Health and/or Statement of Insurability form may be required for coverage to be approved.

Note: Coverage is for new elections only. Existing coverage will remain in force unless cancelled by You.
Coverage not elected will be considered refused even if not specifically declined.

Critical Illness	☐ Yes ☐ No	Applicant Benefit Amount: $	☐ Applicant Only ☐ Applicant/Spouse ☐ Applicant/Child ☐ Family
Accident Expense	☐ Yes ☐ No	☐ Applicant Only ☐ Applicant/Child ☐ Applicant/Spouse ☐ Family	

Applicant's Name _____

C. Beneficiaries — Unless shown differently below, survivors share equally. If additional space is needed, attach a separate sheet of paper.

Applicant Beneficiaries

Legal Name *(First, Middle, Last)*	Relationship	P=Primary C=Contingent	Date of Birth	Social Security No.	Share %
			/ /		
			/ /		

D. Certification and Authorization

I certify that the statements and answers provided in this enrollment form were made by me, are complete and true, and have been correctly and fully recorded. I agree that this enrollment form constitutes my application and shall form a part of the certificate if attached thereto. My statements and answers are offered as an inducement to grant insurance, and I understand that Assurity may use misstatements or misrepresentations in the application to contest the validity of any coverage provided. I understand that any premiums deducted before the issue date of the certificate are pre-paid premiums and will be applied to coverage beginning on the issue date. If the certificate is not issued, Assurity will refund any premium deductions it receives. I further authorize my employer to deduct from my salary or wages the necessary premium for the coverage(s) requested *(including dependents' coverage)*.

For Health Products Only: I further understand that the insurance applied for shall be in force as of the certificate issue date shown on the certificate schedule and not the date the application is signed.

For Life Products Only: Coverage issued on this enrollment form for any person starts on the date of this enrollment, ONLY IF that person is insurable on that date, at Assurity's standard rates according to its underwriting practices, for the amount of life insurance and any additional benefits applied for.

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a substantial civil penalty where and to the extent allowed by state law.

Signature of Primary Proposed Insured _____ on ____/____/____

GLENWOOD COMMUNITY
SCHOOL DISTRICT