The choice is yours.

2025-2026
Health Benefit Guide

BENEFITS FOR A HEALTHY LIFE

ADM COMMUNITY SCHOOLS

WELCOME TO YOUR BENEFITS ENROLLMENT

We recognize how important benefits are to you. That's why we're committed to helping you and your family enjoy the best possible physical, financial, and emotional well-being. It's also why we provide you with a comprehensive, highly competitive benefits package, with the flexibility to make the choices that best meet your needs. Use this guide to better understand your 2025-2026 benefits options. Then, be sure to make your choices by the enrollment deadline, **Tuesday May 20, 2025,** to receive coverage for the coming year.

Inside this guide

Important reminders

- **If you want to keep your current benefits or change your benefit for July 1, 2025**, you must take the time and complete enrollment through Benefitsolver.
- There are new offerings in Medical, Dental and a **NEW** Voluntary Life/AD&D program that you need to review. Your current benefits will not carry forward. This includes any FSA account you have selected.
- **New employees: Enroll within 30 days from your date of hire.** If you don't enroll within this time period, you will not have benefits coverage, except for plans and programs that are fully paid for by ADM CSD, such as Group Life/AD&D, Long Term-Disability Income.
- **Open Enrollment: Enroll before the enrollment deadline.** If you miss the deadline and don't enroll or make changes to your benefits, you'll receive only those benefits that are fully paid for by ADM CSD or medical, dental or vision benefits previously selected. Additionally, you won't be able to participate in any FSAs and you'll have to wait until the next Open Enrollment, unless you experience a qualified life event, to enroll or change benefits. The deadline for enrollment is **May 20, 2025 at 11:59pm**, if you want to receive the updated benefits selected for the 2025-2026 plan year.

Who can enroll?

- **Full-time employees (30+ hrs./wk.) –** Eligible upon hire; must choose benefits within 30 days of hire date.
- **Part-time employees –** Must average at least 30 hrs./wk. during a 6-month period to be eligible.
- **Eligible dependents –** Includes your legal spouse/domestic partner and children to age 26, plus disabled dependent children of any age who meet plan criteria.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 54 for more details.

Summary of Benefits and Coverage

The Health section of this guide provides an overview of your medical plan options. You can find detailed information about each plan, including a breakdown of costs, in each plan's Summary of Benefits and Coverage (SBC). The SBCs summarize important information about your health coverage options in a standard format to help you compare costs and features across plans. The SBCs are available on page 24-51 in this benefit guide.

HEALTH

Perhaps the most important decision you'll make when enrolling is choosing a medical and prescription drug plan that's right for your and your family. Be sure to evaluate your needs along with costs before you decide.

Medical

For 2025, you have a choice of medical plans giving you the flexibility to choose what's best for your needs and budget.

- **HMO** offers inexpensive in-network coverage only. Out-of-network services are generally not covered, unless it is an emergency service.
- **POS 750** lowest premium costs and coverage is based on who you see in the POS (Point of Service) network. Unlike the HMO, you may have out-of-network coverage depending on the providers participation in BCBS networks. You receive best level of coverage if you stay within the Wellmark POS network.
- **Copay 1250 PPO (FROZEN) as of July 1, 2025,** the plan, allows participants to see any doctor or specialist, but they typically pay less when using in-network providers. The PPO plan usually comes with high premiums and out-of-pocket expenses. **Next Year this plan will be discontinued.**
- **HDHP 2500 PPO** - HDHP/HSA plan, features low premiums in exchange for a high deductible. This plan is designed to work with a tax-advantaged savings account (HSA).

➢ **HMO and POS plans requires you to designate a Primary Care Physician (PCP) for each person covered on your HMO plan.**

- Only complete the PCP section on Benefitsolver if you are electing the HMO or POS 750 plan **for the 1st time**.
- If you are currently enrolled in the HMO or POS 750 you should log into your **www.Wellmark.com** account to check or change your PCP.

Key features

All of ADM CSD's medical plans offer:

- Comprehensive, affordable coverage for a wide range of health care services.
- Flexibility to see any provider you want with the PPO Plans, although you'll save money when you stay in-network.
- In-network preventive care, with services covered at 100%, including annual physicals, recommended immunizations, well-woman and well-child exams, flu shots, vision exams and routine cancer screenings.
- Prescription drug coverage included with each medical plan.
- Financial protection through annual out-of-pocket maximums that limit the amount you'll pay each year.
- Choice of coverage levels: Employee, Employee +1, and Family.

Compare medical plans

The chart below provides a comparison of key coverage features and costs.

Provider Network / Plan Name	HMO		POS 750	
	In-network	Out-of-network	In-network	Out-of-network
Annual deductible				
Per person/per family	$0		$750 Single	$1500 Family
Out-of-pocket maximum				
Per person/per family	$750 Single	$1,500 Family	$1,500 Single	$3,000 Family
Medical coverage				
Office Visit - Designated PCP	$5 Copay	Not Covered	$10 Copay	Deductible, then 20% Coinsurance
Office Visit – Network PCP and MHCD Office Visits	$10 Copay	Not Covered	$15 Copay	Deductible, then 20% Coinsurance
Preventive – Includes Vision Exam	No Charge	Not Covered	No Charge	Not Covered
Specialist – Network Non-PCP	$10 Copay	Not Covered	$30 Copay	Deductible, then 20% Coinsurance
Telemedicine – Dr on Demand	$10 Copay	Not Covered	$15 Copay	Deductible, then 20% Coinsurance
Hospital Facility – Inpatient / Outpatient	10% Coinsurance	Not Covered	Deductible, then 10% Coinsurance	Deductible, then 20% Coinsurance
Emergency Room	$50 Copay		Deductible, then 10% Coinsurance	
Diagnostic Tests (Labs and X-rays)	**Independent Lab** $10 Copay **Facility** 10% Coinsurance	Not Covered	**Independent Lab** $30 Copay **Facility** Deductible, then10% Coinsurance	Deductible, then 20% Coinsurance
Infertility Services	Up to $15,000 lifetime	Not Covered	Up to $15,000 lifetime	
Retail prescription drugs (30-day supply)				
Tier 1	$5 Copay	$5 Copay	$8 Copay	$8 Copay
Tier 2	$10 Copay	$10 Copay	$35 Copay	$35 Copay
Tier 3	$10 Copay	$10 Copay	$50 Copay	$50 Copay
Mail Order Drug – 3 Copays for Retail 90 days supply	**2 Copays for Mail Order Maintenance Drug 90-day supply**			
Specialty Drugs				
Generic / Biosimilar	$50 Copay	Not Covered	$50 Copay	Not Covered
Preferred	$85 Copay		$85 Copay	
Non-Preferred	$100 Copay		$100 Copay	
Drug Card Out-of-Pocket Maximum (Accumulates Separate from Medical)	$1,500 Single	$3,000 Family	$1,500 Single	$3,000 Family

- **Primary Care Practitioner (PCP)** is defined as General Practice, Family Practice, Internal Medicine, Obstetrics/Gynecology, Pediatricians, Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants.
- **Network Primary Care Practitioner (PCP)** is defined as Chiropractors, Speech Pathologists, Physical Therapists, and Occupational Therapists. Includes Office Mental Health/Chemical Dependency.
- **Network Non-Primary Care Practitioners (Non-PCP)** includes All other providers.

Compare medical plans

The chart below provides a comparison of key coverage features and costs.

Provider Network / Plan Name	Copay 1250 PPO (FROZEN) No new enrollment after June 30, 2025 Last year for this plan		HDHP 2500 PPO NEW PLAN –July 1, 2025	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Annual deductible				
Per person/per family	$1,250 Single	$2,500 Family	$2,500 Single	$5,000 Family
Out-of-pocket maximum				
Per person/per family	$2,500 Single	$5,000 Family	$2,500 Single	$5,000 Family
Medical coverage				
Office Visit PCP	$10 Copay	Deductible, then 30% Coinsurance	Deductible, then 0% Coinsurance	Deductible, then 0% Coinsurance
Preventive – Includes Vision Exam	No Charge	Deductible, then 30% Coinsurance	No Charge	Deductible, then 0% Coinsurance
Specialist	$10 Copay	Deductible, then 30% Coinsurance	Deductible, then 0% Coinsurance	Deductible, then 0% Coinsurance
Telemedicine – Dr on Demand	$10 Copay	Deductible, then 30% Coinsurance	Deductible, then 0% Coinsurance	Deductible, then 0% Coinsurance
Hospital Facility – Inpatient / Outpatient	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance	Deductible, then 0% Coinsurance	Deductible, then 0% Coinsurance
Emergency Room	Deductible, then 20% Coinsurance		Deductible, then 0% Coinsurance	
Diagnostic Tests (Labs and X-rays)	Deductible, then 20% Coinsurance	Deductible, then 30% Coinsurance	Deductible, then 0% Coinsurance	Deductible, then 0% Coinsurance
Infertility Services	Up to $25,000 lifetime		Up to diagnosis	
Retail prescription drugs (30-day supply)				
Tier 1	$10 Copay	$10 Copay	Deductible, then 0% Coinsurance	Deductible, then 0% Coinsurance
Tier 2	$20 Copay	$20 Copay	Deductible, then 0% Coinsurance	Deductible, then 0% Coinsurance
Tier 3	$30 Copay	$30 Copay	Deductible, then 0% Coinsurance	Deductible, then 0% Coinsurance
Mail Order Drug Copay 1250 only – 3 Copays for Retail 90 days supply 2 Copays for Mail Order Maintenance Drug 90-day supply				
Specialty Drugs				
Generic	$50 Copay	Not Covered	Deductible, then 0% Coinsurance	Not Covered
Preferred	$85 Copay		Deductible, then 0% Coinsurance	
Non-Preferred	$100 Copay		Deductible, then 0% Coinsurance	
Drug Card Out-of-Pocket Maximum (Accumulates Separate from Medical)	$500 Single	$1,000 Family	Not Applicable	

Money-saving tips

To stretch your health care dollars, remember to:

- **See in-network providers** who have agreed to accept lower negotiated rates. Visit Wellmark's website www.Wellmark.com to search for in-network providers near you.
- **Use the mail-order pharmacy** to save time and money when refilling long-term prescriptions.

A closer look at the HDHP

The high-deductible health plan (HDHP) costs you less from your paycheck, allowing you to keep more money and potentially save on health care costs by being an active health care consumer.

Features of a low-cost, high-deductible plan

1. Managing costs

Your per-paycheck costs are lower compared to ADM's other health plans, giving you the opportunity to budget the extra money saved in a way that works best for you and your family.

2. Tax-advantaged accounts

When you select a qualified health plan, you may be eligible to participate in programs to help you pay for certain medical expenses tax-free. You may also be able to use these programs to pay for dental, vision, or other services.

Note: Programs may have eligibility requirements you must meet before you can enroll.

You won't pay federal income taxes on qualified withdrawals from a tax-advantaged account. Consult your tax advisor to learn more on how a tax-advantaged account may affect your state or federal taxes.

3. Free in-network preventive care

As with all ADM's health plans, preventive care is fully covered — you pay nothing toward your deductible and no copays when you receive care from in-network providers. Preventive care includes annual physicals, well-child and well-woman exams, immunizations, flu shots, vision exam and cancer screenings.

4. Extensive provider network

You can receive care from Wellmark Blue Cross/Blue Shield's large network of doctors and other health care providers.

Using a high-deductible plan

1	**Free Preventive Care**	You pay nothing for in-network preventive care.
2	**Deductible***	You pay health care expenses up to the annual deductible amount.
3	**Out-of-pocket Maximum***	You're protected by an annual limit on costs. The plan pays 100% once you've paid this amount during the year.

*Deductible and out-of-pocket maximum (OPM) are the same amount under the HDHP 2500.

Money-saving tip

Put more money into your pocket by enrolling in a higher deductible plan and use this extra cash to budget however makes the most sense to you.

Health Savings Account (HSA)

If you enroll in the HDHP, you may be eligible to open an HSA. An HSA is a tax-free savings account you can use to pay for eligible health expenses anytime, even in retirement.

How does an HSA work?

Build tax-free savings. You can make before-tax deductions from your paycheck into your HSA, allowing you to save money by using pre-tax dollars to pay for eligible medical and Rx, dental, and vision expenses. The total amount that can be contributed to your HSA each year is limited by the IRS. The following are the IRS limits for 2025:

- Up to $4,300 for employee-only coverage.
- Up to $8,550 if you cover dependents.
- Add $1,000 to these limits if you're age 55 or older.
- *These are 2025 limits. The limits for 2026 had not been released at the time this guide was printed.*

Keep your money. Unlike an FSA, the money in your HSA is always yours to keep and can be rolled over from year to year. You can take your unused balance with you when you retire or leave ADM CSD.

Use it like a bank account. Pay for eligible expenses for yourself and your family and then reimburse yourself for payments you've made (up to the available account balance). Remember, you may only access money that is in your HSA when making a purchase or withdrawal. Be sure to keep receipts for your records.

Earn interest and invest for the future. Once your interest-bearing HSA reaches a minimum balance, you may be able to invest in a variety of no-load mutual funds like 401(k) investments. You can learn more at www.baseonline.com or call 1-888-227-3105.

Never pay taxes. Contributions are made on a before-tax basis, and your withdrawals will never be subject to federal income taxes when used for eligible expenses. Any interest or earnings on your HSA balance build tax-free, too.*

** Money in an HSA grows tax-free and can be withdrawn tax-free if it is used to pay for qualified health care expenses (for a list of eligible expenses, see IRS Publication 502, available at www.irs.gov). If money is used for ineligible expenses, you will pay ordinary income tax on the amount withdrawn plus a 20% penalty tax before age 65. After age 65, withdrawals for ineligible expenses are not penalized. Please review your state regulations as you may have to pay state taxes depending on your residency.*

HSA eligibility

To establish and contribute to an HSA, you:

- Must be enrolled in a high deductible health plan, like ADM CSD's HDHP 2500.
- Cannot be covered by any other medical plan that is not a qualified high deductible plan. This includes a spouse's medical coverage unless it's an HSA-qualified plan.
- Cannot be enrolled in a traditional health care FSA in 2025-2026.
- 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.
- FSA Funds are ineligible to roll over to an HSA.

Flexible Spending Accounts (FSAs)

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.

Flexible Spending Accounts

ADM CSD offers you the following FSAs:

Health Care FSA

- Pay for eligible health care expenses, including out-of-pocket expenses such as plan deductibles, copayments, and coinsurance, but not insurance premiums.
- Contribute up to $3,300 per Plan Year.

Dependent Care FSA

- Pay for eligible dependent care expenses, such as day care or adult dependent care, so you can work, look for work, or attend school full time.
- Contribute up to $5,000 in 2025, or $2,500 per spouse if you are married and file separate tax returns.

Estimate carefully

Keep in mind, FSAs are generally "use-it-or-lose-it" accounts. You must use the money in an FSA within the plan year, which is July 1, 2025 – June 30, 2026.

But ADM CSD offers the following:

- An option to carry over up to $660 in your Health Care FSA to 2026 to use during that plan year.

Note: Please see your plan documents if you have any questions.

** These are 2025 limits. The limits for 2026 had not been released at the time this guide was printed.*

HSA vs. Health Care FSA: What's the difference?

	HSA	Health Care FSA
Available if you enroll in a …	**HDHP 2500**	**PPO Plan HMO Plan POS Plan**
Change your contribution amount any time	Yes	No
Access your entire annual contribution amount from the beginning of the plan year	No	Yes
Access only funds that have been deposited	Yes	No
"Use-it-or-lose-it" at year-end	No	Yes**
Money is always yours to keep	Yes	No

*** Except for allowed rollover amount.*

Managing your FSA(s)

When you enroll in a Health Care FSA, you will receive a debit card, which you can use to pay for eligible expenses. Depending on the transaction, you may need to submit receipts or other documentation to your FSA administrator.

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 – New Offerings

Delta Dental of Iowa has discontinued the plans ADM CSD provided for you last year. You now have these two new plans to consider.

Healthy teeth and gums are important to your overall wellness. That's why it's important to have regular dental checkups and maintain good oral hygiene. Learn about the dental plans available to help you maintain your oral health.

To find out what network your dentist falls in, go to **www.deltadentalia.com**.

Coverage Plan B – Delta Dental **Percentages Shown are the Insured's Responsibility**	**PPO Dentist**	**Premier Dentist**	**Out-of-Network Dentist**
Annual deductible (per person/per family)	$25 / $75	$50 / $150	$75 / $225
Calendar-year maximum		$1,000	
Preventive/diagnostic services (Check-up and Teeth Cleaning)	Deductible Waived 0% Coinsurance	Deductible Waived 0% Coinsurance	Deductible, then 20% Coinsurance
Periodontal Maintenance Therapy Bitewing X-Rays	Deductible then, 50% Deductible then, 10%	Deductible then, 50% Deductible then, 20%	Deductible then, 60% Deductible then, 40%
Routine and Restorative Services (Cavity Repair and Tooth Extractions)	Deductible then, 10%	Deductible then, 20%	Deductible then, 40%
Posterior Composites w/o Alternate Processing	Deductible then, 50%	Deductible then,50%	Deductible then, 60%
Endodontic and Periodontal Services	Deductible then, 50%	Deductible then, 50%	Deductible then 60%
High-Cost Restorations & Prosthetic Services (Cast Restorations, Dentures & Bridges) Implants Not Covered	Deductible then, 50%	Deductible then, 50%	Deductible then 60%
Orthodontia	50% Coinsurance with Lifetime Maximum $1,000		

Coverage Plan C – Delta Dental **Percentages Shown are the Insured's Responsibility**	**PPO Dentist**	**Premier Dentist**	**Out-of-Network Dentist**
Annual deductible per individual	$25	$50	$75
Calendar-year maximum		$1,000	
Preventive/diagnostic services (Check-up and Teeth Cleaning)	Deductible Waived 10% coinsurance	Deductible Waived 20% coinsurance	Deductible, then 30% Coinsurance
Bitewing X-Rays	Deductible then, 20%	Deductible then, 30%	Deductible then, 40%
Routine and Restorative Services (Cavity Repair and Tooth Extractions)	Deductible then, 20%	Deductible then, 30%	Deductible then, 40%
Posterior Composites w/o Alternate Processing	Deductible then, 50%	Deductible then,50%	Deductible then, 60%
Endodontic and Periodontal Services	Not Covered	Not Covered	Not Covered
High-Cost Restorations & Prosthetic Services (Cast Restorations, Dentures & Bridges)	Not Covered	Not Covered	Not Covered

Dental 2025-2026 Monthly deductions (before tax deduction)

	Employee Only	**Two Person**	**Family**
Plan B Monthly Cost	$35.12	$72.24	$114.42
Plan C Monthly Cost	$19.62	$38.42	$76.76

Money-saving Tip

Remember, you can use medical FSA or health savings account (HSA) for qualified out-of-pocket dental and vision expenses.

Vision

Having vision coverage allows you to save money on eligible eye care expenses, such as periodic eye exams, eyeglasses, contact lenses, and more for you and your covered dependents. **Below are the in-network benefits**, if you chose a out-of-network Eye Doctor, then you will be subject to lesser benefit amounts and you are responsible for claim submission. To find out what network provider visit **www.avesis.com**.

Coverage		Buy-up Plan Vision with Exam In-Network Benefits	Base Plan Materials Only In-Network Benefits
Exam	Copay	$10 Copay Retinal Imaging – Up to $45	Not Covered under Vision Plan
	Frequency	Annually	
Prescription glasses	Copay	$15 Copay	$15 Copay
Lenses	Single	Covered in Full after Copay	Covered in Full after Copay
	Bifocal (Lined)	Covered in Full after Copay	Covered in Full after Copay
	Trifocal (Lined)	Covered in Full after Copay	Covered in Full after Copay
	Lenticular	Covered in Full after Copay	Covered in Full after Copay
	Other Lens Options	**Allowances** Standard Scratch Resistance Coating - $17 Ultraviolet Screening - $15 Solid or Gradient Tint - $17 Standard Anti Reflective Coating - $45 Progressive Lenses $75-$110 Other Lens Options 20% discount	Discounted up to 20% off Retail
	Frequency	Annually	Annually
Frames	Allowance	$50 Wholesale Allowance Up to $150 Retail Value Up to 20% discount over Retail Walmart/Sams Club - $68 Costco - $54.99	$50 Wholesale Allowance Up to $150 Retail Value Up to 20% discount over Retail Walmart/Sams Club - $68 Costco - $54.99
	Frequency	Every 24 Months	Every 24 months
Contact lenses*	Elective	$130 Allowance	$130 Allowance
	Medical Necessary	Paid in Full	Paid in Full

*Contact lenses (instead of glasses)

Vision 2025-2026 Monthly deductions (before tax deduction)

	Single	Employee + Spouse	Employee + Child(ren)	Family
Buy-up Plan	$10.53	$20.16	$21.96	$28.27
Base Plan	$7.76	$14.69	$16.00	$20.59

Reminder: Annual routine vision exam is covered in full for you and any family members you cover on your District medical plan.

Focus on wellness

ADM is committed to helping you feel your best and live well. We offer benefits and programs that support your total health and make it easier to pursue your wellness goals.

Wellness program

Our wellness program is designed to help you maintain or move toward a healthy lifestyle through preventive care and other assistance when you need it. You also have access to tools and resources you can use to learn about your personal health risks and monitor progress toward your health goals.

Employee Assistance Program

The Adel-DeSoto-Minburn CSD Employee Assistance Program (EAP) is available throughout the year to assist with your everyday needs, at no cost to you. It's all part of our commitment to supporting your total well-being.

Get help with work-life issues; referrals for clinical, legal, and financial services; and more. To begin taking advantage of this valuable benefit, visit www.guidanceresources.com or call 800 964 3577. Login instructions included on page 16.

Take advantage of preventive care benefits

Good preventive care can help you stay healthy and detect any "silent" problems early, when they're most likely to be treatable. Most in-network preventive services are covered in full, so there's no excuse to skip it.

- **Have a routine physical exam each year.** You'll build a relationship with your doctor and can reduce your risk for many serious conditions.
- **Get regular dental cleanings.** Numerous studies show a link between regular dental cleanings and disease prevention — including lower risks of heart disease, diabetes, and stroke.
- **See your eye doctor at least once every two years**. If you have certain health risks, such as diabetes or high blood pressure, your doctor may recommend more frequent eye exams.
- **Listen up! Your ears could be telling you something** Delta Dental of Iowa now offers hearing discount benefits. For more information, Call 866-925-1698. Or visit www.deltadentalia.com/hearing. This is a discount plan only. It is through Amplifon Hearing Health Care.

Don't have a personal doctor? You should. Here's why-

- **Better health.** Getting the right health screenings each year can reduce your risk for many serious conditions. And remember, preventive care doesn't cost you anything.
- **A healthier wallet.** A PCP can help you avoid costly trips to the emergency room. Your doctor will also help coordinate specialist care, if needed.
- **Peace of mind.** Advice from someone you trust means a lot when you're healthy, but it's even more important when you're sick.

Get care from your couch

When you don't feel well, or your child is sick, the last thing you want to do is leave the comfort of your home to sit in a crowded waiting room full of other sick people. A virtual consultation lets you talk with a doctor from the comfort of your home or office. Virtual visits cost about the same as in-person office visits.

Consider a virtual visit when your doctor isn't available, you become ill while traveling, or you're considering visiting a hospital emergency room for a non-emergency health condition. To learn more and register, go to www.doctorondemand.com.

Doctor on Demand also helps with behavior health services too. **Get signed up today so you will have it ready when you need it.**

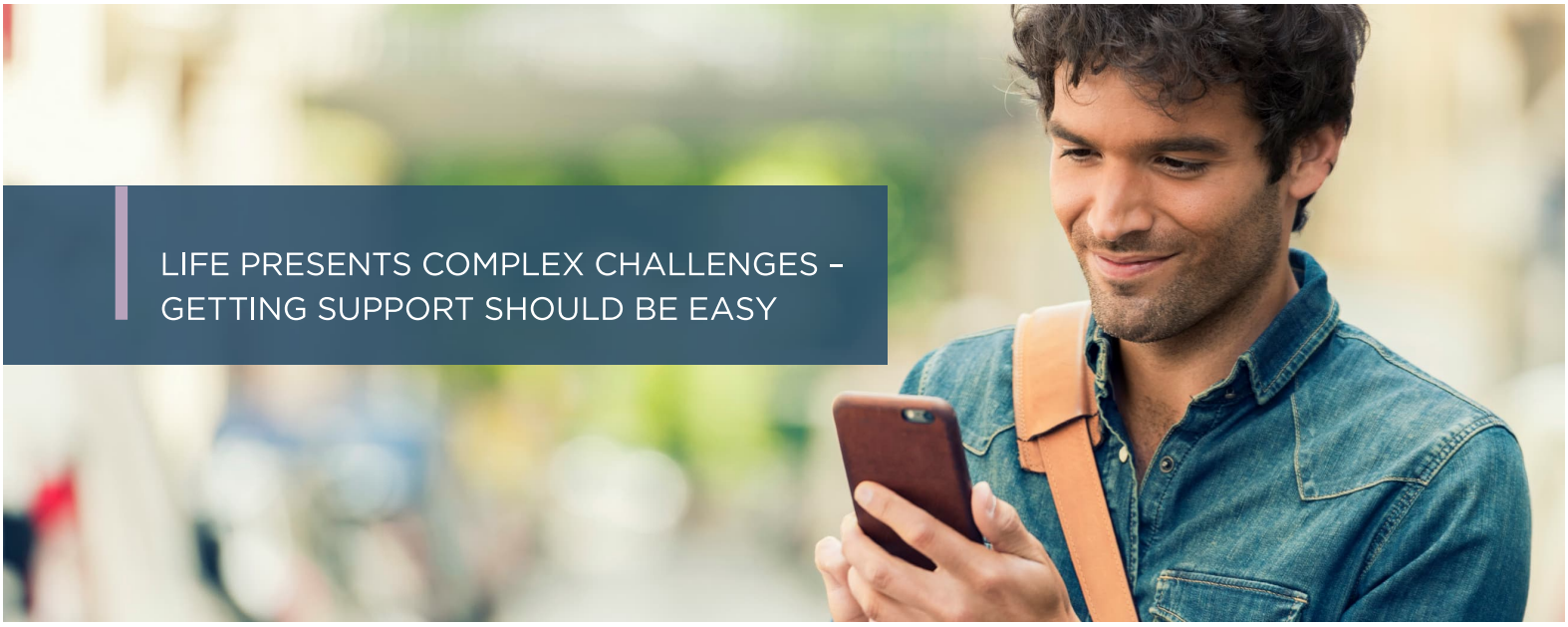
Health Advocacy Resources

Questions on your coverage, claims, diagnosis, treatments, Medicare?

Contact Health Advocate experts who can support you as you navigate the healthcare system. Assistance is available to you, your family, parents and parents-in-law.

Visit www.healthadvocate.com for more information

Did you receive a surprise bill? You may be able to lower bills for medical / dental services by using Health Advocate to research and negotiate claims.



LIFE PRESENTS COMPLEX CHALLENGES – GETTING SUPPORT SHOULD BE EASY

If the unexpected happens, you should have simple solutions to help you cope with the stress and life changes that may result. That's why The Hartford's Enhanced Ability Assist Counseling Services, offered by ComPsych®,[1] can play such an important role. Our straightforward approach takes the complexity out of benefits when life throws you a curve.

COMPASSIONATE SOLUTIONS FOR COMMON CHALLENGES

From everyday issues like job pressures, relationships, retirement planning to highly impactful issues like grief, loss, or disability, Ability Assist® is your resource for professional support.

SERVICE FEATURES

The service includes up to three face-to-face counseling sessions per occurrence per year. This means you and your dependents won't have to share visits. You can each get counseling help for your unique needs. Counseling for your legal, financial, medical and benefit-related concerns is also available by phone.

EXTRAS THAT SUPPORT AND ASSIST

For access over the phone, simply call toll-free **800-96-HELPS** (800-964-3577).

Visit **www.guidanceresources.com** to access hundreds of personal health topics and resources for child care, elder care, attorneys or financial planners.

IF YOU'RE A FIRST-TIME USER, CLICK ON THE REGISTER TAB.

1. In the Organization Web ID field, enter: **HLF902**
2. In the Company Name field at the bottom of personalization page enter: **ABILI**
3. After selecting "**Ability Assist program**", create your own confidential user name and password.

(Snap a photo with a mobile device to capture the information above)

THE HARTFORD

ENHANCED ABILITY ASSIST COUNSELING SERVICES

Emotional or Work-Life Counseling	Helps address stress, relationship or other personal issues you or your dependents may face. It is staffed by GuidanceExperts℠—highly trained master's-level clinicians — who listen to concerns and quickly make referrals to in-person counseling or other valuable resources. Situations may include: • Job pressures • Relationship/marital conflicts • Stress, anxiety and depression • Work/school disagreements • Substance abuse • Child and elder care referral services
Financial Information and Resources	Provides unlimited telephonic support for the complicated financial decisions you or your dependents may face. Speak by phone with a Certified Public Accountant and Certified Financial Planners on a wide range of financial issues. Topics may include: • Managing a budget • Retirement • Getting out of debt • Tax questions • Saving for college
Legal Support and Resources	Offers unlimited telephonic assistance if legal uncertainties arise. Talk to an attorney by phone about the issues that are important to you or your dependents. If you require representation, you'll be referred to a qualified attorney in your area with a 25% reduction in customary legal fees thereafter. Topics may include: • Debt and bankruptcy • Guardianship • Buying a home • Power of attorney • Divorce
Health Care Navigation	HealthChampion℠ is a service that supports you through all aspects of your health care issues by helping to ensure that you're fully supported with employee assistance programs and/or work-life services.[2] HealthChampion is staffed by both administrative and clinical experts who understand the nuances of any given health care concern. Situations may include: • One-on-one review of your health concerns • Preparation for upcoming doctor's visits/lab work/tests/surgeries • Answers regarding diagnosis and treatment options • Coordination with appropriate health care plan provider(s) • An easy-to-understand explanation of your benefits–what's covered and what's not • Cost estimation for covered/non-covered treatment • Guidance on claims and billing issues • Fee/payment plan negotiation

Check with your benefits manager for more information on **Enhanced Ability Assist**

THE HARTFORD

[1] The services described in this material are offered through The Hartford by ComPsych® Corporation. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. The Hartford is not responsible and assumes no liability for the goods and services provided by ComPsych and reserves the right to discontinue any of these services at any time. Services may not be available in all states. California residents are limited to three prepaid behavioral health counseling sessions in any six-month period. Except for acute emergencies and other special circumstances, additional sessions for California employees are available on a fee-for-service basis. Visit www.TheHartford.com/employee-benefits/value-added-services for more information.

[2] HealthChampion℠ specialists are only available during business hours. Inquiries outside of this timeframe can either request a call-back the next day or schedule an appointment.

4359 05/21

FINANCIAL

Group Life/AD&D paid by ADM CSD

NEW BENEFIT – Supplemental Life Insurance

Employee basic life and AD&D insurance

You automatically receive basic life and accidental death and dismemberment (AD&D) insurance so that you can protect those you love from the unexpected. There is no cost to you for this coverage. Your benefit amount will be $40,000.

NEW Employee supplemental life and AD&D insurance

Now is the time! ADM CSD is providing you, as a full-time employee, an opportunity to purchase additional life/AD&D for yourself, your spouse/domestic partner and/or children. The coverage is through The Hartford and premium will be paid through payroll deduction.

You, the employee, can enroll up to the Guarantee Issue maximum $160,000 without evidence of insurability. You can choose from $20k to $160k in $20k increments.

If you don't enroll now, and you want to later, you will have to complete evidence of insurability (EOI) for any amount elected.

NEW Spouse/domestic partner voluntary life and AD&D insurance

You may also purchase additional life/AD&D insurance for your spouse or domestic partner. You can elect from $10,000 up to $50,000 or 50% of your elected amount, whichever is greater. Guaranteed Issue for spouse/domestic partner is $50,000.

A Few Items to Remember

- Rates are per $1,000 of coverage
- Spouse/domestic partner rates are based on employee age
- Coverage terminates upon retirement or termination of employment, whichever comes first
- Spouse/domestic partner coverage max is $50,000 or ½ of employee elected amount
- Children are covered from birth to age 26. Each child is covered for $10,000 for $2.00 per month. All amounts are guarantee issue.
- Must have employee coverage to elect spouse and/or child(ren) coverage
- Each annual enrollment you may increase you and your spouse/domestic partner's election amount by 1 level with no evidence of insurability.
  - Ex. Increase election from $80,000 to $100,000 = No EOI. Increase from $80,000 to $120,000 = EOI applies on amount from $100,000 to $120,000.

What is AD&D insurance?

Should you lose your life, sight, hearing, speech or use of your limb(s) in an accident, AD&D provides additional benefits to help keep your family financially secure. AD&D benefits are paid as a percentage of your coverage amount — from 50% to 100% — depending on the type of loss.

Have you named a beneficiary?

Be sure you've selected a beneficiary for all your life and accident insurance policies. The beneficiary will receive the benefit paid by a policy in the event of the policyholder's death. It's important to designate a beneficiary and keep that information up-to-date. Visit www.Benefitsolver.com to add or change a beneficiary.

NEW Supplemental Life Insurance Rates

July 1, 2025

Rates per $1,000 of coverage	
The Hartford	**Employee and Spouse Supplemental Life/AD&D Rates**
Younger than 30	$0.077
30-34	$0.096
35-39	$0.106
40-44	$0.153
45-49	$0.215
50-54	$0.319
55-59	$0.486
60-64	$0.790
65-69	$1.417
70-74	$2.080
Child Life	$2.00 Covers all dependent Children

Disability Insurance

The loss of income due to illness or disability can cause serious financial hardship for your family. Our disability insurance programs work together to replace a portion of your income when you're unable to work. The disability benefits you receive allow you to continue paying your bills and meeting your financial obligations during this difficult time.

Summary of disability benefits

	Basic Long-Term Disability
Who pays	ADM CSD
Benefit	60% up to $5,000 Maximum Monthly Benefit
Maximum benefit duration	2 Year own occupation Mental Health/Substance Abuse – Limitation 24 months
Elimination period	120 days

Do you have a Will?

As an employee of ADM CSD and coverage with The Hartford Group Life Insurance, you have access to EstateGuidance ® Will Service provided by ComPsych®. This free service helps you create a simple, legally binding will online, saving you the time and expense of a private legal consultation.

Visit **www.estateguidance.com** and enter this promotional code: WILLHLF

Employee assistance program

If you are covered under the District Long Term Disability plan you have access to counseling services provided through ComPsych. This confidential service helps with everyday issues, at no cost to you. It's all part of our commitment to supporting your total well-being. Get help with work-life issues, referrals for clinical, legal, and financial services and more. Unlimited online/phone resources and up to 3 in-person visits.

To begin taking advantage of this valuable benefit, visit **www.guidanceresources.com** or call 800 964 3577.

1st time user, click Register. Organization WEB Id Field enter: HLF902; Company name enter: ABILI. After selecting "Ability Assist program", create your own userid and password.

ENROLL

Don't wait! Review your benefits now and decide what works best for you and your family. Before your enrollment deadline, name a beneficiary, confirm dependent eligibility, and elect your 2025 - 2026 benefits to ensure you receive coverage.

How to enroll

Enroll for your benefits through Benefitsolver.

Online

Log in to www.benefitsolver.com

Enroll from any computer with internet access, 24 hours a day, seven days a week. Follow the prompts to set up your account and select a secure password.

Your opportunity to make and/or update your benefits for the 2025-2026 plan year is from Monday, April 28, 2025 – Tuesday, May 20, 2025, at 11:59pm.

Changes during the year

After your enrollment opportunity ends, you won't be able to change your benefits coverage during the year unless you experience a qualifying life event, such as marriage, divorce, birth, adoption, or a change in your or your spouse/domestic partner's employment status that affects your benefits eligibility.

Effective date of coverage

For new employees, the effective date of coverage for most plans is first of the month following date of hire.

For existing employees enrolling during Open Enrollment, the effective date is July 1, 2025.

Contacts

Please contact the appropriate provider listed below to learn more about a specific benefit plan.

Benefit Plan	Provider	Phone Number	Website
Medical	Wellmark Blue Cross/Blue Shield of Iowa	1-800-524-9242	www.Wellmark.com/member
Prescriptions	Wellmark Blue Cross/Blue Shield of Iowa CVS Caremark	1-800-524-9242	www.Wellmark.com/prescriptions
Health Savings Account (HSA)	BASE	1-888-227-3105	www.baseonline.com/private/login.asp
Flexible Spending Accounts (FSAs)	BASE	1-888-227-3105	www.baseonline.com/private/login.asp
Dental	Delta Dental of Iowa	1-800-544-0718	www.deltadentalia.com
Vision	Avesis	1-855-214-6777	www.Avesis.com
Employee assistance program (EAP)	ComPsych	1-800-964-3577	www.guidanceresources.com
Personal Health Advocate	Health Advocate	1-866-695-8622	www.healthadvocate.com/members
Telemedicine services	Doctor On Demand	1-800-997-6196	www.doctorondemand.com
Life and AD&D insurance	The Hartford	1-888-301-5615	www.thehartford.com/learn/egit
Disability insurance	The Hartford	1-888-301-5615	www.thehartford.com/learn/egit

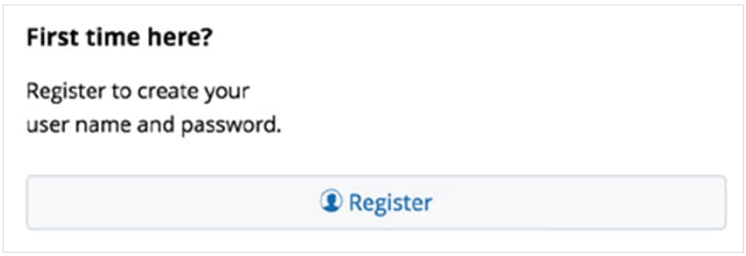
How to enroll in your benefits

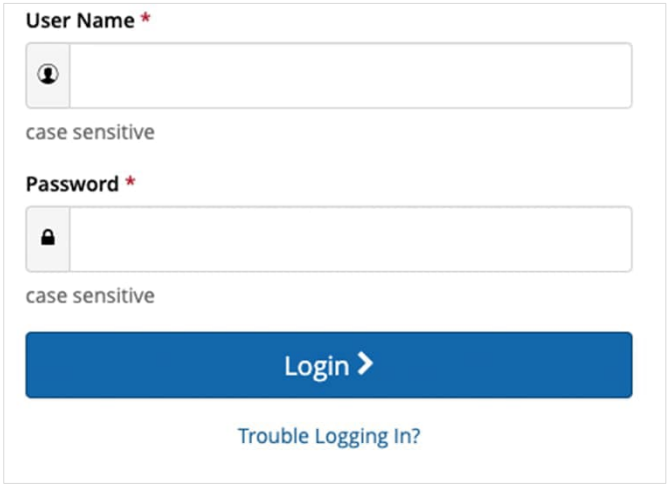
benefitsolver

Iowa Educator's Trust

REGISTER AND LOGIN

1. Visit **www.benefitsolver.com** and click the **Register** button to get started. The case-sensitive company key is **etrust**.
2. Create your username and password, verify your personal information, and answer a few security questions.
3. Log in using your new username and password.





RETURNING USERS: Click the **Trouble Logging In?** link to reset your login details.

EXPLORE YOUR OPTIONS

Explore the site to learn about your benefits. You'll find lots of helpful information in the **Reference Center**, located at the top of the page in the navigation menu.

The calendar at the top of the **Home** page lets you know how many days you have left to enroll.

START YOUR ENROLLMENT

Please note that a ribbon at the top of the screen will alert you that Annual Enrollment is available. **Tap Start Here to begin.**

Click the **Start Enrollment** button to review your personal information and add or edit any dependents you wish to cover.

If you are adding dependent(s) to your coverage, you will need to provide each dependent's legal name, Social Security number, and birth date.*

**You may be required to provide documentation to prove your relationship to each dependent.*

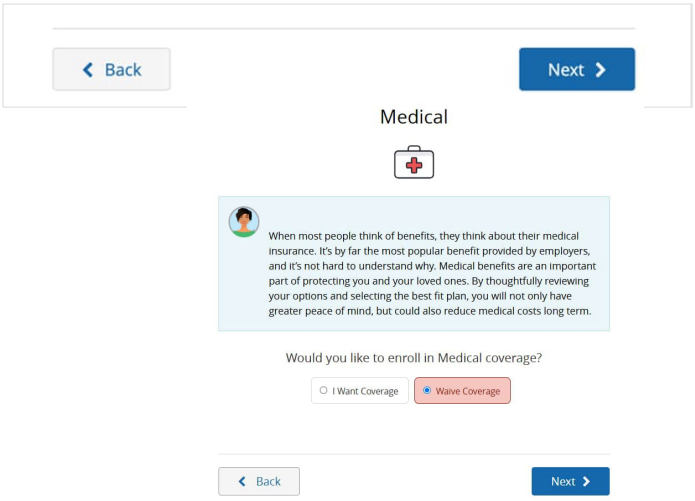
www.Benefitsolver.com
Company Key: etrust

ENROLL IN COVERAGE

After you've reviewed your information and added any necessary dependents, you will move forward with electing your benefits:

Use the **Next** and **Back** buttons to review and elect options available to you. DO NOT use your browser's arrows to navigate between pages. Choose or decline coverage for each option and select which family members you want to cover.

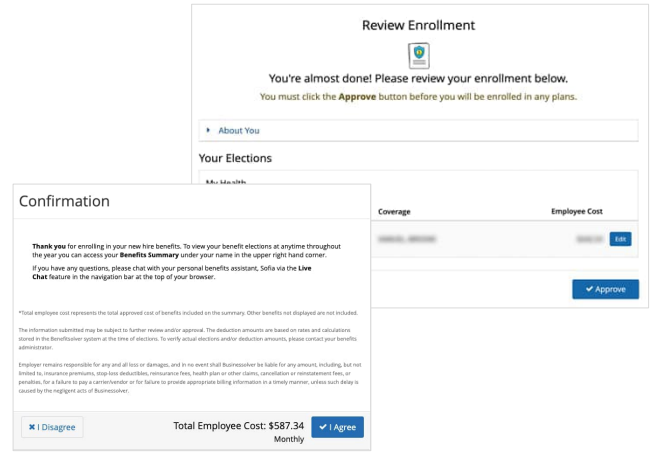
Review plan documents and use the **Compare** and **Plan Details** tools to view details and costs for the options available to you.



REVIEW AND FINALIZE YOUR ELECTIONS

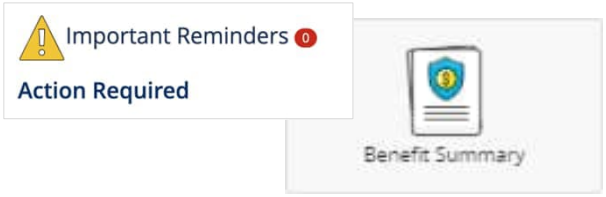
After you've reviewed each individual benefit election, it's time to review your enrollment at large. Make sure your personal information, elections, dependents, and beneficiary designations are accurate, then **Approve** your elections.

To finish, click **I Agree.** When your enrollment is complete, you will receive a confirmation number and can print your **Benefit Summary** for your records.

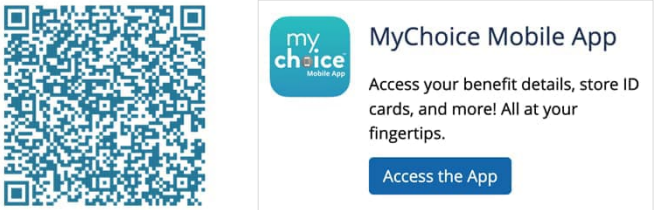


Once approved, your benefit elections will remain in effect until the end of the plan year, unless you have a qualifying life event such as marriage, divorce, or having a baby. These changes must be made within 30 days of the event and documentation may be required. Find detailed information in the **Reference Center.** Beneficiary changes can be made at any time of the year.

AFTER YOU ENROLL



1. Check your **Important Reminders** for actions needed to complete your enrollment.
2. Access your **Benefit Summary** for accuracy of your information and elections.
3. Download the **MyChoice® benefits app** to manage and access all your benefits information on the go. Click **Access the App** to get started or scan the QR code to the right to download the app on your device.
4. Visit this site year-round to learn more about your benefits, find plan information, and access tools to improve your health.



www.Benefitsolver.com
Company Key: etrust

benefitsolver®

Notes

Summaries of Benefits and Coverage (SBCs)

Wellmark Health Plan of Iowa

IAED HMO

Coverage Period: 07/01/2025 – 06/30/2026
Coverage for: Single & Family | Plan Type: HMO

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 1-866-807-9430. 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 1-866-807-9430 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0** person 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?	No. This plan has no deductibles.	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?	Health: **$750** person/**$1,500** family per calendar year. Drug Card: **$1,500** person/**$3,000** family per calendar year. The In-Network health and drug card out-of-pocket maximum amounts accumulate separately.	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 1-866-807-9430 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	$5 Designated PCP copay per provider per date of service $10 copay per provider per date of service	Not covered	For this plan you must select a Designated Primary Care Provider (PCP). PCP provider types can be found in the What You Pay section of your plan document.
	Specialist visit	$10 copay per provider per date of service	Not covered	Applies to Non-PCP providers. Hearing exams are covered according to ACA guidelines. $10 copay per provider per date of service for in-network chiropractic services.
	Preventive care/screening/ immunization	No charge	Not covered	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)	Independent Lab: $10 copay per provider per date of service Facility: 10% coinsurance	Not covered	For a test in a provider's office or clinic, your cost is included in the cost-share listed above. Waive cost-share on in-network independent lab services for mental health/ substance abuse.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not covered	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 1-866-807-9430. You can find your Coverage Manual at sbccmfinder.wellmark.com.

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	$5 copay per prescription	$5 copay per prescription	Refer to your Blue Rx Value Plus Drug List to determine the tier that applies to a covered drug. For out-of-network prescription drugs, you may be balance billed. 1 copay for 30-day supply. 3 copays for 90-day supply (retail). 2 copays for 90-day supply (mail order). Specialty drugs are covered only when obtained through the CVS Specialty Pharmacy Program. Specialty drugs on the PrudentRx drug list (found at Wellmark.com) will have 30% coinsurance. If you enroll with PrudentRx, you will have $0 member cost-share for drugs on the PrudentRx drug list. 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	$10 copay per prescription	$10 copay per prescription	
	Tier 3	$10 copay per prescription	$10 copay per prescription	
	Specialty drugs	Generic: $50 copay per prescription Preferred: $85 copay per prescription Non-preferred: $100 copay per prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	-----None-----
	Physician/surgeon fees	10% coinsurance	Not covered	-----None-----

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-866-807-9430. You can find your Coverage Manual at sbccmfinder.wellmark.com.

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	$50 copay per facility per date of service for facility and physician(s) combined	$50 copay per facility 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	10% coinsurance	10% coinsurance	For covered non-emergent situations, out-of-network ground ambulance services are NOT reimbursed at the in-network level. You 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 provider per date of service for facility and physician(s) combined	Not covered	------None------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	------None------
	Physician/surgeon fees	10% coinsurance	Not covered	------None------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $10 copay per provider per date of service Facility: 10% coinsurance	Not covered	------None------
	Inpatient services	10% coinsurance	Not covered	------None------

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-866-807-9430. You can find your Coverage Manual at sbccmfinder.wellmark.com.

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	No charge	Not covered	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	No charge	Not covered	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	10% coinsurance	Not covered	------None------
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not covered	------None------
	Rehabilitation services	Office: $10 copay per provider per date of service Facility: 10% coinsurance	Not covered	------None------
	Habilitation services	Office: $10 copay per provider per date of service Facility: 10% coinsurance	Not covered	------None------
	Skilled nursing care	10% coinsurance	Not covered	------None------
	Durable medical equipment	10% coinsurance	Not covered	Orthopedic shoes, shoe inserts and accessories are covered. Trusses for back or hernia support are covered.
	Hospice services	10% coinsurance	Not covered	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	One routine vision exam per calendar year. Must be performed by an in-network provider.
	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 1-866-807-9430. You can find your Coverage Manual at sbccmfinder.wellmark.com.

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
- Non-emergency care when traveling outside the U.S.
- 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 ($15,000 LTM)
- 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 Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 1-866-807-9430, Iowa Insurance Division at 515-654-6600, or Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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.

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	$0
PCP copayment	$5
Hospital(facility) coinsurance	10%
Other no charge	No Charge

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	$0
Copayments	$10
Coinsurance	$750
What isn't covered	
Limits or exclusions	**$60**
The total Peg would pay is	**$820**

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

The plan's overall deductible	$0
Specialist copayment	$10
Hospital(facility) coinsurance	10%
Other coinsurance	10%

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	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	**$20**
The total Joe would pay is	**$520**

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

The plan's overall deductible	$0
Specialist copayment	$10
Hospital(facility) copayment	$50
Other coinsurance	10%

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	$0
Copayments	$100
Coinsurance	$100
What isn't covered	
Limits or exclusions	**$0**
The total Mia would pay is	**$200**

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 Health Plan of Iowa

IAED 750 POS

Coverage Period: 07/01/2025 – 06/30/2026
Coverage for: Single & Family | Plan Type: HMO

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 1-866-807-9430. 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 1-866-807-9430 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$750** person/**$1,500** 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, preventive care from in-network providers, in-network physician maternity care, in-network prosthetic limbs, mammograms and services subject to health and drug card 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?	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?	Health: **$1,500** person/**$3,000** family per calendar year. Drug Card: **$1,500** person/**$3,000** family per calendar year. The In-Network health and drug card out-of-pocket maximum amounts accumulate separately.	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 1-866-807-9430 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.

Important Questions	Answers	Why this Matters:
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 Designated PCP copay per provider per date of service $15 copay per provider per date of service	20% coinsurance	For this plan you must select a Designated Primary Care Provider (PCP). PCP provider types can be found in the What You Pay section of your plan document.
	Specialist visit	$30 copay per provider per date of service	20% coinsurance	Applies to Non-PCP providers. $15 copay per provider per date of service for in-network chiropractic services. Hearing exams are covered according to ACA guidelines.
	Preventive care/screening/ immunization	No charge	Not covered	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)	Indep Labs: $30 copay per provider per date of service Facility: 10% coins	20% coinsurance	For a test in a provider's office or clinic, your cost is included in the cost-share listed above. Waive cost-share on in-network independent lab services for mental health/ substance abuse.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% 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 1-866-807-9430. You can find your Coverage Manual at sbccmfinder.wellmark.com.

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	$8 copay per prescription	$8 copay per prescription	Refer to your Blue Rx Value Plus Drug List to determine the tier that applies to a covered drug. For out-of-network prescription drugs, you may be balance billed. 1 copay for 30-day supply. 3 copays for 90-day supply (retail). 2 copays for 90-day supply (mail order). Specialty drugs are covered only when obtained through the CVS Specialty Pharmacy Program. Specialty drugs on the PrudentRx drug list (found at Wellmark.com) will have 30% coinsurance. If you enroll with PrudentRx, you will have $0 member cost-share for drugs on the PrudentRx drug list. 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	$35 copay per prescription	$35 copay per prescription	
	Tier 3	$50 copay per prescription	$50 copay per prescription	
	Specialty drugs	Generic: $50 copay per prescription Preferred: $85 copay per prescription Non-preferred: $100 copay per prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	-----None-----
	Physician/surgeon fees	10% coinsurance	20% coinsurance	-----None-----
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	For emergency medical conditions treated OON, 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	10% coinsurance	10% coinsurance	For covered non-emergent situations, OON ground ambulance services are NOT reimbursed at the IN level. You may be balance billed for any OON service as established under the rules developed for implementation of the No Surprises Act.
	Urgent care	$30 copay per provider per date of service for facility and physician(s) combined	20% coinsurance	$15 copay per provider per date of service applies to services for mental health/substance abuse.

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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 hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	------None------
	Physician/surgeon fees	10% coinsurance	20% coinsurance	------None------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $15 copay per provider per date of service Facility: 10% coinsurance	20% coinsurance	------None------
	Inpatient services	10% coinsurance	20% coinsurance	------None------
If you are pregnant	Office visits	No charge	20% 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	No charge	20% 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	10% coinsurance	20% coinsurance	------None------

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-866-807-9430. You can find your Coverage Manual at sbccmfinder.wellmark.com.

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	10% coinsurance	20% coinsurance	------None------
	Rehabilitation services	Office: $15 PCP/$30 Non-PCP copay per provider per date of service Facility: 10% coinsurance	20% coinsurance	$15 copay per provider per date of service applies to in-network Physical and Occupational Therapists and Speech Language Pathologists.
	Habilitation services	Office: $15 PCP/$30 Non-PCP copay per provider per date of service Facility: 10% coinsurance	20% coinsurance	$15 copay per provider per date of service applies to in-network Physical and Occupational Therapists and Speech Language Pathologists.
	Skilled nursing care	10% coinsurance	20% coinsurance	------None------
	Durable medical equipment	10% coinsurance	20% coinsurance	Orthopedic shoes, shoe inserts and accessories are covered. Trusses for back or hernia support are covered.
	Hospice services	10% coinsurance	20% coinsurance	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.
If your child needs dental or eye care	Children's eye exam	No charge	20% coinsurance	One routine vision exam per calendar year. Must be performed by an in-network provider.
	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 1-866-807-9430. You can find your Coverage Manual at sbccmfinder.wellmark.com.

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 ($15,000 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 Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 1-866-807-9430, Iowa Insurance Division at 515-654-6600, or Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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.

Wellmark Health Plan of Iowa, Inc. is an independent licensee of the Blue Cross and Blue Shield Association.

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

About These Coverage Examples:

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

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

The plan's overall deductible	$750
PCP copayment	$10
Hospital(facility) coinsurance	10%
Other no charge	No Charge

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	$750
Copayments	$10
Coinsurance	$750
What isn't covered	
Limits or exclusions	**$60**
The total Peg would pay is	**$1,570**

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

The plan's overall deductible	$750
Specialist copayment	$30
Hospital(facility) coinsurance	10%
Other coinsurance	10%

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	$50
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	**$20**
The total Joe would pay is	**$1,270**

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

The plan's overall deductible	$750
Specialist copayment	$30
Hospital(facility) coinsurance	10%
Other coinsurance	10%

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	$750
Copayments	$200
Coinsurance	$100
What isn't covered	
Limits or exclusions	**$0**
The total Mia would pay is	**$1,050**

Claim examples calculate benefits based on services provided by your Designated Primary Care Provider.

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

Coverage Period: 07/01/2025 – 06/30/2026
Coverage for: Single & Family | Plan Type: PPO

IAED Copay 1250 PPO

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 1-866-807-9430. 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 1-866-807-9430 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,250** person/**$2,500** 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, in-network routine vision exams, in-network prosthetic limbs, mammograms and services subject to health and drug card 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?	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?	Health: **$2,500** person/**$5,000** family per calendar year. Drug Card: **$500** person/ **$1,000** family per calendar year. The In-Network health and drug card out-of-pocket maximum amounts accumulate separately.	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 1-866-807-9430 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.

Important Questions	Answers	Why this Matters:
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	30% coinsurance	----None----
	Specialist visit	$10 copay per date of service	30% coinsurance	Hearing exams are covered according to ACA guidelines.
	Preventive care/screening/ immunization	No charge	30% 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)	20% coinsurance	30% coinsurance	For a test in a provider's office or clinic, your cost is included in the cost-share listed above. In-network independent labs for mental health/substance abuse services are not subject to coinsurance.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% 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 1-866-807-9430. You can find your Coverage Manual at sbccmfinder.wellmark.com.

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	Refer to your Blue Rx Value Plus Drug List to determine the tier that applies to a covered drug. For out-of-network prescription drugs, you may be balance billed. 1 copay for 30-day supply. 3 copays for 90-day supply (retail). 2 copays for 90-day supply (mail order). Specialty drugs are covered only when obtained through the CVS Specialty Pharmacy Program. Specialty drugs on the PrudentRx drug list (found at Wellmark.com) will have 30% coinsurance. If you enroll with PrudentRx, you will have $0 member cost-share for drugs on the PrudentRx drug list. 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	$30 copay per prescription	$30 copay per prescription	
	Specialty drugs	Generic: $50 copay per prescription Preferred: $85 copay per prescription Non-preferred: $100 copay per prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	-----None-----
	Physician/surgeon fees	20% coinsurance	30% coinsurance	-----None-----
If you need immediate medical attention	Emergency room care	20% coinsurance	20% 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	20% coinsurance	20% coinsurance	For covered non-emergent situations, out-of-network ground ambulance services are NOT reimbursed at the in-network level. You 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	30% coinsurance	-----None-----

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-866-807-9430. You can find your Coverage Manual at sbccmfinder.wellmark.com.

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 hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	------None------
	Physician/surgeon fees	20% coinsurance	30% 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	30% coinsurance	------None------
	Inpatient services	20% coinsurance	30% coinsurance	------None------
If you are pregnant	Office visits	20% coinsurance	30% 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	30% 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	30% coinsurance	------None------

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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	20% coinsurance	30% coinsurance	------None------
	Rehabilitation services	Office: $10 copay per date of service Facility: 20% coinsurance	30% coinsurance	------None------
	Habilitation services	Office: $10 copay per date of service Facility: 20% coinsurance	30% coinsurance	------None------
	Skilled nursing care	20% coinsurance	30% coinsurance	------None------
	Durable medical equipment	20% coinsurance	30% coinsurance	Orthopedic shoes, shoe inserts and accessories are covered. Trusses for back or hernia support are covered.
	Hospice services	20% coinsurance	30% coinsurance	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.
If your child needs dental or eye care	Children's eye exam	No charge	30% 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------

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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 Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 1-866-807-9430, Iowa Insurance Division at 515-654-6600, or Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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.

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	$1,250
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	$1,250
Copayments	$50
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	**$60**
The total Peg would pay is	**$2,560**

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

The plan's overall deductible	$1,250
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	$50
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	**$20**
The total Joe would pay is	**$670**

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

The plan's overall deductible	$1,250
Specialist copayment	$10
Hospital(facility) coinsurance	20%
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	$1,250
Copayments	$60
Coinsurance	$100
What isn't covered	
Limits or exclusions	**$0**
The total Mia would pay is	**$1,410**

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

Coverage Period: 07/01/2025 – 06/30/2026
Coverage for: Single & Family | Plan Type: PPO HDHP

IAED HDHP 2500 PPO

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 1-866-807-9430. 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 1-866-807-9430 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,500** person/**$5,000** 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, the overall family deductible must be met before the plan begins to pay.
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?	**$2,500** person/**$5,000** 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, the overall family out-of-pocket limit must be 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 1-866-807-9430 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% 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----
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	Refer to your Blue Rx Value Plus Drug List to determine the tier that applies to a covered drug. You pay the discounted cost of your prescription drugs until your deductible is met. For out-of-network prescription drugs, you may be balance billed. 30-day supply for prescription drugs. 90-day prescription maximum. Specialty drugs are covered only when obtained through the CVS Specialty Pharmacy Program. Specialty drugs on the PrudentRx drug list (found at Wellmark.com) will have 30% coinsurance. If you enroll with PrudentRx, you will have $0 member cost-share for drugs on the PrudentRx drug list once your deductible is met. 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	

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-866-807-9430. You can find your Coverage Manual at sbccmfinder.wellmark.com.

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)	0% coinsurance	0% coinsurance	-----None-----
	Physician/surgeon fees	0% coinsurance	0% coinsurance	-----None-----
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. You 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 1-866-807-9430. You can find your Coverage Manual at sbccmfinder.wellmark.com.

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	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.
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 1-866-807-9430. You can find your Coverage Manual at sbccmfinder.wellmark.com.

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 (excludes some services)
- 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 Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 1-866-807-9430, Iowa Insurance Division at 515-654-6600, or Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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.

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

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

About These Coverage Examples:

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

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

The plan's overall deductible	$2,500
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	$2,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	**$60**
The total Peg would pay is	**$2,560**

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

The plan's overall deductible	$2,500
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	$2,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	**$20**
The total Joe would pay is	**$2,520**

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

The plan's overall deductible	$2,500
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	$2,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	**$0**
The total Mia would pay is	**$2,500**

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 complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes. Wellmark does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Wellmark

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call 800-524-9242.

If you believe that Wellmark has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Wellmark Civil Rights Coordinator, 1331 Grand Avenue, Station 3E417, Des Moines, IA 50309-2901, 515-376-6500, TTY 888-781-4262, Fax 515-376-9055, Email **CRC@Wellmark.com**. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Wellmark Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

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

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

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

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

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

تنبيه: إذا كنت تتحدث اللغة العربية, فإننا نوفر لك خدمات المساعدة اللغوية، المجانية. اتصل بالرقم ٨٠٠-٥٢٤-٩٢٤٢ أو (خدمة الهاتف النصي: ٨٨٨-٧٨١-٤٢٦٢).

ສິ່ງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານ ໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ທີ່. (TTY: 888-781-4262.)

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

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

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

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

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

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

တၢ်ဒုးသ့ဉ်ညါ–နမ့ၢ်ကတိၤကညီကျိာ်,ကျိာ်တၢ်မၤစၢၤတၢ်ဖံးတၢ်မၤတဖဉ်,လၢတဘဉ်လာ်ဘူးလဲ,အိဉ်လၢနဂီၢ်လီၤ.ဆဲးကျိးဆူ 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) ይውለው ያነጋግሩን።

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

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

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

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

Employer Notices

Important Notice to Employees
ADM Community School District
About Creditable Prescription Drug Coverage and Medicare

The purpose of this notice is to advise you that the prescription drug coverage listed below under the ADM Community School District medical plan are expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2026. This is known as “creditable coverage.”

Why this is important. If you or your covered dependent(s) are enrolled in any prescription drug coverage during 2026 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty – as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren’t currently covered by Medicare and won’t become covered by Medicare in the next 12 months, this notice doesn’t apply to you.

Please read the notice below carefully. It has information about prescription drug coverage with ADM Community School District and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

Notice of creditable coverage

You may have heard about Medicare’s prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by one of the ADM Community School District prescription drug plans listed below, you’ll be interested to know that the prescription drug coverage under the plans is, on average, at least as good as standard Medicare prescription drug coverage for 2026. This is called creditable coverage. Coverage under one of these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

Copay 1250 Frozen Plan, HMO, POS 750, HDHP 2500

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the ADM Community School District plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop ADM Community School District coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment or other qualifying event or otherwise become newly eligible to enroll in the ADM Community School District plan mid-year, assuming you remain eligible.

You should know that if you waive or leave coverage with ADM Community School District and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future – such as before the next period you can enroll in Medicare prescription drug coverage, if this ADM Community School District coverage changes, or upon your request.

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. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

- Visit medicare.gov for personalized help.
- Call your State Health Insurance Assistance Program (see a copy of the Medicare & You handbook for the telephone number) or visit the program online at https://www.shiptacenter.org/.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact:

Joshua W. Jacobs
Business Manager/Board Secretary
ADM Community School District
215 N 11th Street
Adel IA 50003
Phone: 515-993-4283

Notice of Special Enrollment Rights for Health plan coverage

As you know, if you have declined enrollment in ADM Community School District 's health plan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under this plans without waiting for the next open enrollment period, provided that you request enrollment within 30 days after your other coverage ends. 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 eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

ADM Community School District will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have *60 days* – instead of 30– from the date of the Medicaid/CHIP eligibility change to request enrollment in the ADM Community School District group health plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of March 17, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861: Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx OR https://health.alaska.gov/en/services/division-of-public-assistance-services/apply-for-medicaid/
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**

Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**

Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924 OR 1-855-242-8282
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since March 17, 2025, 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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

Women's Health and Cancer Rights Act notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at 515-993-4283.

Newborns' and Mothers' Health Protection Act notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at 515-993-4283.

Michelle's Law notice – Extended dependent medical coverage during student medical leaves

The ADM Community School District Wellmark plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from a post-secondary educational institution (including a college or university). Coverage may continue for up to a year, unless the child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school – or change in school enrollment status (for example, switching from full-time to part-time status) – starts while the child has a serious illness or injury, is medically necessary and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If the coverage provided by the plan is changed during this one-year period, the plan will provide the changed coverage for the remainder of the leave of absence.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, you must contact your Human Resources Department as soon as the need for the leave is recognized to ADM Community School District. In addition, contact you may need to call Wellmark Blue Cross/Blue Shield of Iowa's customer service to see if there is additional requirements. Their phone number is on the back of your ID Card. They will be able to see if any state laws requiring extended coverage may apply to his or her benefits.

Marketplace/Exchange Notice

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.02% for 2025 of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.02% for 2025[1] of the employee's household income.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Joshua Jacobs - Business Manager/Board Secretary at 515-993-4283.

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name: ADM Community School District	4. Employer Identification Number (EIN): 42-1398258	
5. Employer address: 215 North 11th Streeet	6. Employer phone number: 515-993-4283	
7. City Adel	8. State: Iowa	9. Zip code: 50003
10. Who can we contact about employee health coverage at this job? Joshua W Jacobs - Business Manager - Board Secretary		
11. Phone number (if different from above)	12. Email address: josh.jacobs@admschools.org	

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

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ■ Some employees. Eligible employees are:

    Those employees who meet the definition of an eligible employee as defined in the medical coverage manual

- With respect to dependents:
  - ■ We do offer coverage. Eligible dependents are:

    Those dependents who meet the definition of an eligible dependent as defined in the medical coverage manual

  - ☐ We do not offer coverage.

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

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

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

☐ **Yes** (Continue)
If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $_____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly
☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.[2] (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly
☐ Quarterly ☐ Yearly

*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 (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

ADM Community School District HIPAA privacy notice

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by ADM Community School District health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of these plans: Medical, Dental, Vision and FSA. The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties with respect to health information about you

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not ADM Community School District as an employer — that's the way the HIPAA rules work. Different policies may apply to other ADM Community School District programs or to data unrelated to the Plan.

How the Plan may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.
- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.
- **Health care operations** include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

How the Plan may share your health information with ADM Community School District

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to ADM Community School District for plan administration purposes. ADM Community School District may need your health information to administer benefits under the Plan. ADM Community School District agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Human Resources and/or Business Manager are the only ADM Community School District employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and ADM Community School District, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose "summary health information" to ADM Community School District, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer or HMO, may disclose to ADM Community School District information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that ADM Community School District cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by ADM Community School District from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is *not* protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody

Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protective services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or

programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

Your individual rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

- The access or copies you requested
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment, or health care operations
- To you about your own health information
- Incidental to other permitted or required disclosures
- Where authorization was provided

- To family members or friends involved in your care (where disclosure is permitted without authorization)
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances
- As part of a “limited data set” (health information that excludes certain identifying information)

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You’ll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on **July 1, 2025,** However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan’s privacy policies described in this notice, you will be provided with a revised privacy notice by e-mailed.

Complaints

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won’t be retaliated against for filing a complaint. To file a complaint*,* contact the Human Resources Department, or Joshua Jacobs, Business Manager/Board Secretary at 515-993-4283.

Contact

For more information on the Plan’s privacy policies or your rights under HIPAA, contact, Human Resources Department, or Joshua Jacobs, Business Manager/Board Secretary *at* 515-993-4283.

Provider-Choice Rights Notice – For PPO Plans

1. The Wellmark Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Wellmark's website at www.wellmark.com or customer service - phone number is on the back of your Wellmark ID card.

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

3. You do not need prior authorization from or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Wellmark's website at www.wellmark.com or customer service - phone number is on the back of your Wellmark ID card.

Provider-Choice Rights Notice - For HMO Plans

1. The Wellmark Health Plan of Iowa generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, The Wellmark Health Plan of Iowa will not issue coverage. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the provider by using the phone number on the back of your Wellmark Member ID Card

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

3. You do not need prior authorization from Wellmark Health Plan of Iowa or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Wellmark Health Plan of Iowa at the provider by using the phone number on the back of your Wellmark Member ID Card

No Surprises Act notice

Your Rights and Protections Against Surprise Medical Bills

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

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

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

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

Certain services at an in-network hospital or ambulatory surgical center

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

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

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

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

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

If you believe you've been wrongly billed, you may contact U.S. Department of Health and Human Services beginning January 1, 2022 at 1-800-985-3059. Visit No Surprises Act | CMS for more information about your rights under federal law.

Visit www.legis.iowa.gov for more information about your rights under Iowa state law.

YOUR RIGHTS UNDER USERRA

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

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

REEMPLOYMENT RIGHTS

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

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

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

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- ☆ are a past or present member of the uniformed service;
- ☆ have applied for membership in the uniformed service; or
- ☆ are obligated to serve in the uniformed service;

then an employer may not deny you:

- ☆ initial employment;
- ☆ reemployment;
- ☆ retention in employment;
- ☆ promotion; or
- ☆ any benefit of employment

because of this status.

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

HEALTH INSURANCE PROTECTION

- ☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.

- ☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

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

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

- ☆ If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.

- ☆ You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: **http://www.dol.gov/vets/programs/userra/poster.htm**. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

U.S. Department of Labor
1-866-487-2365

U.S. Department of Justice

Office of Special Counsel

1-800-336-4590

Publication Date — April 2017

Your Employee Rights Under the Family and Medical Leave Act

What is FMLA leave?

The Family and Medical Leave Act (FMLA) is a federal law that provides eligible employees with **job-protected leave** for qualifying family and medical reasons. The U.S. Department of Labor's Wage and Hour Division (WHD) enforces the FMLA for most employees.

Eligible employees can take **up to 12 workweeks** of FMLA leave in a 12-month period for:

- The birth, adoption or foster placement of a child with you,
- Your serious mental or physical health condition that makes you unable to work,
- To care for your spouse, child or parent with a serious mental or physical health condition, and
- Certain qualifying reasons related to the foreign deployment of your spouse, child or parent who is a military servicemember.

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

You have the right to use FMLA leave in **one block of time**. When it is medically necessary or otherwise permitted, you may take FMLA leave **intermittently in separate blocks of time, or on a reduced schedule** by working less hours each day or week. Read Fact Sheet #28M(c) for more information.

FMLA leave is **not paid leave**, but you may choose, or be required by your employer, to use any employer-provided paid leave if your employer's paid leave policy covers the reason for which you need FMLA leave.

Am I eligible to take FMLA leave?

You are an **eligible employee** if **all** of the following apply:

- You work for a covered employer,
- You have worked for your employer at least 12 months,
- You have at least 1,250 hours of service for your employer during the 12 months before your leave, and
- Your employer has at least 50 employees within 75 miles of your work location.

Airline flight crew employees have different "hours of service" requirements.

You work for a **covered employer** if **one** of the following applies:

- You work for a private employer that had at least 50 employees during at least 20 workweeks in the current or previous calendar year,
- You work for an elementary or public or private secondary school, or
- You work for a public agency, such as a local, state or federal government agency. Most federal employees are covered by Title II of the FMLA, administered by the Office of Personnel Management.

How do I request FMLA leave?

Generally, **to request FMLA leave you must**:

- Follow your employer's normal policies for requesting leave,
- Give notice at least 30 days before your need for FMLA leave, or
- If advance notice is not possible, give notice as soon as possible.

You **do not have to share a medical diagnosis** but must provide enough information to your employer so they can determine whether the leave qualifies for FMLA protection. You **must also inform your employer if FMLA leave was previously taken** or approved for the same reason when requesting additional leave.

Your **employer may request certification** from a health care provider to verify medical leave and may request certification of a qualifying exigency.

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

State employees may be subject to certain limitations in pursuit of direct lawsuits regarding leave for their own serious health conditions. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress.

What does my employer need to do?

If you are eligible for FMLA leave, your **employer must**:

- Allow you to take job-protected time off work for a qualifying reason,
- Continue your group health plan coverage while you are on leave on the same basis as if you had not taken leave, and
- Allow you to return to the same job, or a virtually identical job with the same pay, benefits and other working conditions, including shift and location, at the end of your leave.

Your **employer cannot interfere with your FMLA rights** or threaten or punish you for exercising your rights under the law. For example, your employer cannot retaliate against you for requesting FMLA leave or cooperating with a WHD investigation.

After becoming aware that your need for leave is for a reason that may qualify under the FMLA, your **employer must confirm whether you are eligible** or not eligible for FMLA leave. If your employer determines that you are eligible, your **employer must notify you in writing**:

- About your FMLA rights and responsibilities, and
- How much of your requested leave, if any, will be FMLA-protected leave.

Where can I find more information?

Call **1-866-487-9243** or visit **dol.gov/fmla** to learn more.

If you believe your rights under the FMLA have been violated, you may file a complaint with WHD or file a private lawsuit against your employer in court. **Scan the QR code to learn about our WHD complaint process**.

WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

SCAN ME

This guide is intended to describe the eligibility requirements, enrollment procedures, plan highlights, and coverage effective dates for the benefits offered by Adel-Desoto-Minburn Community School District. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While the guide is a tool to answer many of your benefit questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern the plans' operation. The noted plan changes in this guide may serve as a Summary of Material Modifications (SMM) to the SPD. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will prevail.

24-90738-A 3/25