College Community School District

2026-2027 | All Employees

# Benefits Guide

Your Benefits, Your Choice

## Inside





# Welcome

We understand that your life extends beyond the workplace. That's why we offer a variety of benefits to help you be an advocate of your health and well-being. Our goal is to provide choices for you and your family to be appropriately covered through all stages of life.

## When to Enroll

- **Current Employees:** Open enrollment, starting March 26th, with in person enrollments starting April 6th, is your once-a-year opportunity to adjust benefit coverages and update any dependents and beneficiaries.
- **New Hires:** Once eligible, you must complete your enrollment within 30 days. Some benefits have "guarantee issue" at your first opportunity only, so please carefully consider this before you decline any coverage.

### Enroll with American Fidelity

You will receive an email from the district with contact information for American Fidelity.

## When to Make Changes

Unless you experience a qualifying life event, you cannot make changes to your benefits until the next open enrollment period. An election change must be made within 30 days of the qualifying event. Examples include:

- Marriage, divorce, legal separation, or death of a spouse
- Birth, adoption, or death of a child (60 days)
- Change in child's dependent status
- Change in residence
- Change in employment status or a change in coverage under another employer-sponsored plan

**Medicare Part D Notice:** If you or your dependents are on Medicare or will be eligible within 12 months, federal law offers more prescription drug coverage options. Refer to page **30-31** for details. Please note the HDHP Value Plan is NOT creditable for Medicare Part D.

# Contacts

| College Community School District Benefits Contact | | |
|---|---|---|
| **Lizz Matheny, Payroll and Benefits Specialist** | (319) 848-5215 | lizzmatheny@crprairie.org |

| Coverage | Carrier | Phone Number | Website/Email |
|---|---|---|---|
| **Medical Insurance** | Wellmark | 800-524-9242 | Wellmark.com |
| **Dental Insurance** | Delta Dental | 800-544-0718 | Delta Dental of Iowa |
| **Vision Insurance** | Eye Med | 866-804-0982 | EyeMed.com |
| **Flexible Spending Account** | American Fidelity | | American Fidelity |
| **Health Savings Account** | American Fidelity | | American Fidelity |

## American Fidelity Benefits Site

Scan QR code or visit
https://enroll.americanfidelity.com/B2237CF7

# Eligibility

## Employee Eligibility

As a new employee, you have 30 days from your initial start date to enroll in benefits.

- **Medical, Dental, Vision:** These coverages will take effect on the first of the month following date of hire
- **Other Coverages:*** All other coverages will take effect on the first of the month following date of hire

* **IMPORTANT:** These benefits may require employees to be actively at work at the time benefits become effective. Please review policy documents, or contact our Benefits Specialist, for additional information.

## Dependent Eligibility

If you are enrolled in coverage, you may also have the option to enroll your dependents in coverage.

### Definition of "Eligible Dependents"

**Medical, Dental, and Vision Coverage** dependents include:

- **Your legally married spouse.** Such spouse must have met all requirements of a valid marriage contract of the State in which the marriage of such parties was performed. For the purposes of this definition, "spouse" includes common law spouses.
- **Your dependent children under age 26**. This includes natural, step, foster, adopted, or other children under your legal guardianship.
  - Your dependent children over age 26 who are full-time students will also be covered
- For additional eligibility details, please refer to the policy contract or summary plan documents.

# Medical

Wellmark

Locate an in-network provider near you at Wellmark.com or call 800-524-9242.

Most Plans allow you to visit any doctor or facility you choose—however, you will get the best coverage when you choose an in-network provider. Note the HMO Core Plan does NOT have out of network benefits.

| Medical | HDHP Value | | HMO Core | PPO Core | | PPO Choice | |
|---|---|---|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Annual Deductible**<br>Individual<br>Family | $5,000<br>$10,000 | $10,000<br>$20,000 | $3,000<br>$6,000 | $2,000<br>$4,000 | | $1,250<br>$2,500 | |
| **Coinsurance** (You Pay) | N/A | 25% | 25% | 20% | 40% | 20% | 30% |
| **Annual Out-of-Pocket Maximum**<br>Individual<br>Family | $5,000<br>$10,000 | $20,000<br>$40,000 | $6,000<br>$12,000 | $4,000<br>$8,000 | | $3,500<br>$7,000 | |
| **Services** | In-Network | Out-of-Network | In-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Preventive Care** | Covered 100% | OON Ded, 25% coins. | Covered 100% | Covered 100% | Ded, 40% coins. | Covered 100% | Ded, 30% coins. |
| **Doctor On Demand** | No cost to you | | | | | | |
| **Office Care** | Covered 100% after deductible | OON ded, 25% coins. | $35 PCP; $50 all other | $35 copay | Ded, 40% coins. | $25 copay | Ded, 30% coins. |
| **Independent lab and x-ray** | | | $35 copay | 20% coins. | | 20% coins. | |
| **Emergency Room** | | | Ded, 25% coins. | Ded, 20% coins | | Ded, 20% coins. | |
| **Inpatient/Outpatient hospital care** | | | | | | | |

# MEDICAL CONTINUED

| Class | Medical Monthly Premiums | HDHP Value | HMO Core | PPO Core | PPO Choice |
|---|---|---|---|---|---|
| **Drivers & Aides** | Employee Only | $511 | $604 | $728 | $775 |
| **Drivers & Aides** | Employee + Spouse | $1,047 | $1,239 | $1,492 | $1,589 |
| **Drivers & Aides** | Employee + Child(ren) | $971 | $1,148 | $1,383 | $1,472 |
| **Drivers & Aides** | Family | $1,564 | $1,849 | $2,228 | $2,371 |
| **ECC** | Employee Only | $100 | $100 | $224 | $271 |
| **ECC** | Employee + Spouse | $543 | $735 | $988 | $1,085 |
| **ECC** | Employee + Child(ren) | $467 | $644 | $879 | $968 |
| **ECC** | Family | $1,060 | $1,345 | $1,724 | $1,867 |
| **CCSD Employees** | Employee Only | $0 | $0 | $124 | $171 |
| **CCSD Employees** | Employee + Spouse | $443 | $635 | $888 | $985 |
| **CCSD Employees** | Employee + Child(ren) | $367 | $544 | $779 | $868 |
| **CCSD Employees** | Family | $960 | $1,245 | $1,624 | $1,767 |

Bus Drivers/Aides who work 25 or more hours per week, Monday through Friday, will receive $275 towards elected medical plan coverage.

CCSD employees (excluding Bus Drivers/Aides and ECC) who elect medical coverage receive a **Medical Insurance Allowance** of $124 per month added to their paychecks as additional pay. For CCSD employees who waive medical & dental, with proof of coverage in a qualifying group health plan will receive $125 per month added to their paychecks as **Pay in Lieu of Insurance**.

# Prescription Drugs

| | | HDHP Value | HMO Core | PPO Core | PPO Choice |
|---|---|---|---|---|---|
| Network/coverage | | Blue POS/ Nationwide | Blue HMO/ Iowa only | Blue PPO/ Nationwide | Blue PPO/ Nationwide |
| | | Blue Rx Complete℠ | | | |
| Drug costs | Tier 1 | You pay the full negotiated cost until you have met your deductible/OPM. | $10 | | $10 |
| | Tier 2 | | $50 | | $40 |
| | Tier 3 | | $100 | | $70 |
| | Tier 4 | | $150 | | $100 |
| Specialty drugs | Preferred biosimilar/ generic | You pay the full negotiated cost until you have met your deductible/OPM. | $25 | | $25 |
| | Preferred | | $75 | | $50 |
| | Non-preferred | | $250 | | $200 |
| Out-of-pocket maximum (OPM): Pharmacy | | See **page 2** for OPM. Medical and pharmacy OPMs are combined into one amount. | Single: $3,000 Family: $6,000 | | Single: $2,600 Family: $5,200 |
| | | | Medical and pharmacy OPMs are two separate amounts. See **page 2** for medical OPM. | | |
| Quantity limits | Retail: Tier 1 | Up to a 90-day supply (deductible) | Up to a 90-day supply (3 copays) | | |
| | Retail: Tiers 2, 3 & 4 | Up to a 30-day supply (deductible) | Up to a 30-day supply (1 copay) | | |
| | Mail order: all medications | Up to a 90-day supply (deductible) | Up to a 90-day supply (3 copays) | | |
| Product selection penalty rule | | If a name-brand drug is dispensed when a generic is available, you will pay a penalty: your cost share, plus the difference between the generic drug and the name-brand drug. | | | |

**Please review the full plan documents for details.** If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

# Telemedicine

Doctor on Demand

*Available to employees enrolled in the **medical plan**.*

Telemedicine can be a great alternative to visiting your normal doctor or an urgent care, when you are suffering from one of many common, non-emergency medical conditions.

Using your computer, tablet, or smartphone device, you can conveniently access to U.S. board-certified doctors and licensed professionals from the comfort of your home or wherever you happen to be.

In some cases, doctors can write a prescription to a local pharmacy near you.[1]

## When can I use telemedicine?

- When you need care now.
- If you're considering the ER or urgent care center for a non-emergency issue.
- On vacation, on a business trip, or away from home.
- For short-term prescription refills.

## Access care wherever you are!

1. Download the Doctor On Demand app or visit: Wellmark Member Virtual Doctor Visits - Doctor on Demand

2. Have your Wellmark ID card handy. You'll be asked to enter your full ID number, including the three-character prefix

3. Create an account or sign in

## Get the treatment you need:

- Allergies
- Colds, respiratory problems, flu
- Ear infections
- Sore throat
- Pink eye
- Urinary tract infections

[1] **Prescription services may not be available in all states.**

# Employee Assistance Program

AllOne Health

***Available to all employees.***

Life. Just when you think you've got it figured out, along comes a challenge. This safe and confidential program is here for you and can help you find solutions and peace of mind.

## Confidential Support

- Family Conflict
- Couples/Relationships
- Substance abuse
- Anxiety
- Depression
- Household Errands
- Adoption/Elder Care
- Wellness
- Divorce/Custody
- Budgeting
- Estate Planning
- Bankruptcy
- Any other life struggle you may face

**Connect with a counselor.**

**Telephone, Chat, and Virtual access**

**800-451-1834**

https://portal.allonehealth.com/

Company code: phawks

If you need additional support, the EAP team will try to refer you to resources that are affordable or covered by your medical insurance

# Flexible Spending Account

American Fidelity

FSAs can save you money on eligible expenses because you don't have to pay taxes on the amount contributed to the account. However, using an FSA does require careful planning to reap the financial benefits.

**Is a Health FSA Right for You?**
www.cbmicrosite.com/video/healthfsa

## Health FSA

Pay for eligible medical, dental, vision, and prescription expenses, such as:

- Deductibles
- Copays
- Coinsurance
- Other health-related expenses

| | |
|---|---|
| 2026 annual contribution limit | $3,400 |
| Rollover | $680 |

Your eligibility for an FSA may be misrepresented if you and/or your spouse currently utilize an HSA. Check with the plan administrator or our Benefits Specialist to learn more.

## Limited-Purpose FSA

If you contribute to an HSA, you are only eligible to use a Health FSA for dental and vision expenses only.

| | |
|---|---|
| 2026 annual contribution limit | $3,400 |

## Dependent Care FSA

Set aside tax-free money to care for children under age 13 or an elderly, dependent parent who is unable to care for themselves. Cover care expenses while you work, such as:

- Preschool
- Summer day camp
- Before and after school programs
- Elder care

| | | |
|---|---|---|
| 2026 annual contribution limit | Married (Filing separately) | $3,750 |
| | Single/Married (Filing jointly) | $7,500 |

Visit www.irs.gov and search for IRS Publications 502 (Medical and Dental) and 503 (Dependent Care) to learn more about eligible expenses.

# Health Savings Account

American Fidelity

*Available to employees enrolled in the* ***HDHP medical plan***

If you are enrolled in an HSA-qualified plan, you may be eligible to open a tax-free health savings account. The money in your HSA is carried over from year to year so you can budget for current and future expenses. Plus, you own the account so it's yours to keep even if you change jobs or retire.

**Is an HSA Right for You?**
www.cbmicrosite.com/video/hsa

## HSA

Pay for eligible medical, dental, vision, and prescription expenses, such as:

- Deductibles
- Coinsurance
- Other health-related expenses

| | | |
|---|---|---|
| 2026 annual contribution limit | Individual | $4,400 |
| | Family | $8,750 |
| | Catch-up contribution (Age 55 or older) | $1,000 |
| 2026 annual employer contributions* | Individual | $1,116 |
| Rollover | | Full Amount |

* CCSD & ECC employees who elect HDHP single coverage only will receive $93 per month added to their HSA account

* This amount applies to the IRS annual contribution limit.

All HSA contributions require an open and active account. Contributions cannot be made and are forfeited if no active account exists and cannot be paid later or in a different form.

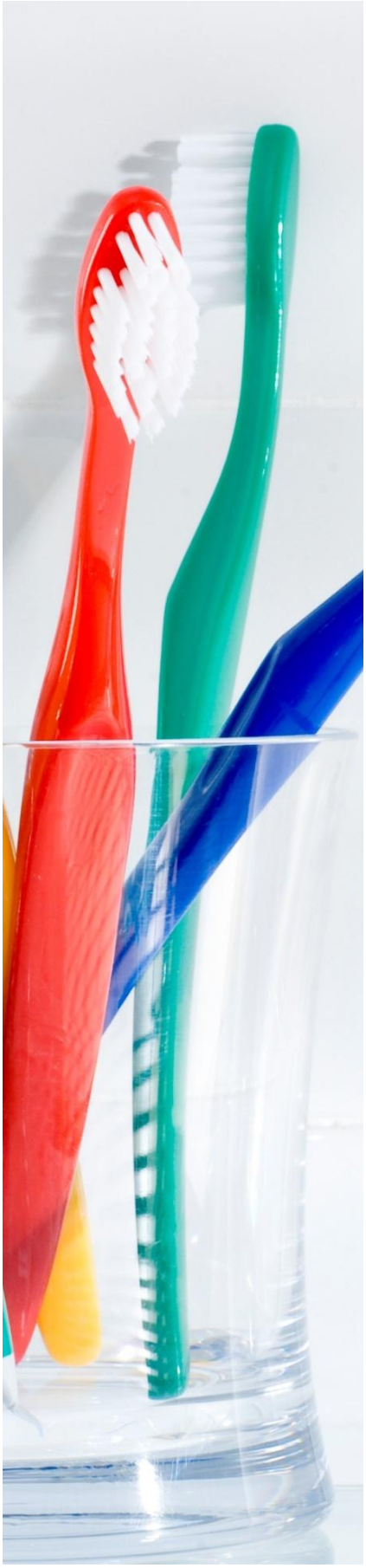
Your eligibility for an HSA may be misrepresented if you and/or your spouse currently utilize an FSA. Check with the plan administrator or our Benefits Specialist to learn more.

Visit www.irs.gov and search for IRS Publication 502 to learn more about eligible expenses.

## HSA Case Study

Justin is a healthy 28-year-old single man who contributes $1,000 each year to his HSA. His plan's annual deductible is $1,600 for individual coverage. Here is a look at the first two years of Justin's HSA plan, assuming the use of in-network providers. This example only includes HSA contribution amounts and does not reflect any investment earnings.

| Year 1 | | → | Year 2 | |
|---|---|---|---|---|
| **HSA Balance** | $1,000 | | **HSA Balance** | $1,850 |
| **Total Expenses:**<br>Prescription drugs: $150 | - $150 | | **Total Expenses:**<br>Office visit: $100<br>Prescription drugs: $200<br>Preventive care services: $0 (covered by insurance) | - $300 |
| **HSA Rollover to Year 2** | $850 | | **HSA Rollover to Year 3** | $1,550 |
| Since Justin did not spend all his HSA dollars in year 1, the remaining funds roll over. | | | Once again Justin did not spend all his HSA dollars, so they roll over to the next year. | |



# Dental

Delta Dental

| Dental | In-Network |
|---|---|
| **Annual Deductible** | $50 per individual<br>$150 per family |
| **Annual Benefit Maximum** | $1,500 |
| **Lifetime Orthodontia Maximum** | $2,000 |
| **Plan Pays** | In-Network |
| **Preventive Care** (Deductible waived) | 100% Covered |
| **Basic** | 80% |
| **Major** | 50% |
| **Orthodontia** | 50% |

| Dental Monthly Cost | ECC, Drivers & Aides | CCSD Employees |
|---|---|---|
| **Employee Only** | $36.00 | $0.00 |
| **Two Person** | $75.00 | $39.00 |
| **Family** | $114.00 | $78.00 |

Locate an in-network provider near you at **Delta Dental of Iowa** or call 800-544-0718.

**Please review the full plan documents for details including out-of-network coverage.** If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

# Vision

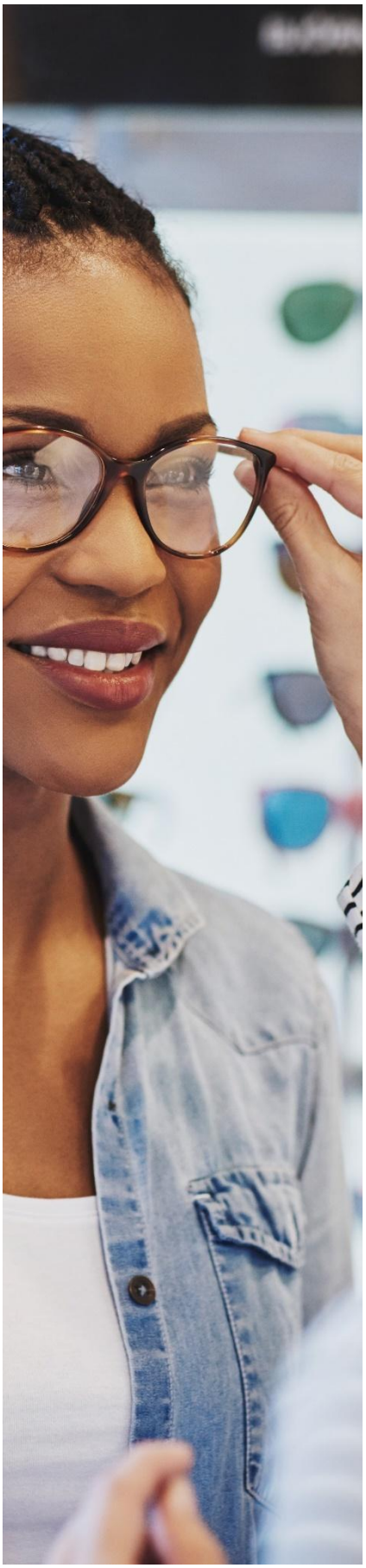
Eye Med

| Vision | Materials Only | Exam + Materials |
|---|---|---|
| | In-Network | In-Network |
| **Exam** | N/A | $10 copay ($0 for Plus Providers) |
| **Lenses** | $10 copay | $10 copay |
| **Frames** | $0 copay; 20% off balance over $150 ($200 with plus providers) | $0 copay; 20% off balance over $150 ($200 with plus providers) |
| **Contact Lenses** | Conventional: $0 copay; 15% off over $150<br>Disposable: $0 copay; 100% off over $150 | Conventional: $0 copay; 15% off over $150<br>Disposable: $0 copay; 100% off over $150 |
| **Frequencies** | | |
| **Exams** | N/A | 1 per 12 months |
| **Lenses or Contacts** | 1 per 12 months | 1 per 12 months |
| **Frames** | 1 per 24 months | 1 per 24 months |

| Vision Cost | Materials Only | Exam + Materials |
|---|---|---|
| **Employee Only** | $5.66 | $7.02 |
| **Family** | $15.39 | $19.09 |

Locate an in-network provider near you at https://www.eyemed.com/en-us/ or call 866-804-0982.

**Please review the full plan documents for details including out-of-network coverage.** If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.



# Life/AD&D

Madison National Life

Life insurance protects your loved ones financially in the event of your death. Accidental death and dismemberment (AD&D) provides an additional benefit if you die or experience other covered catastrophic loss due to a covered accident.

| Basic Life/AD&D | |
|---|---|
| **Benefit Amount** | **Administrators:** $100,000*<br>**Employee:** $40,000 |
| **Benefit Cost** | Employer-provided |

| Voluntary Term Life | |
|---|---|
| **Benefit Amount** | Administrators, Superintendent, Nutritional Employees, Teamsters: $10,000 increments, $50,000 maximum.<br><br>Teachers, Non-bargaining Employees, Confidential Employees: $10,000 increments $100,000 maximum. |

**Benefits may be reduced for employees over age 65 per ADEA.**

**Actively-At-Work Requirement:**
New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-At-Work/eligible status.

## Remember to update your beneficiaries.

It is important to update your beneficiaries and make sure they are accurate periodically. Having out of date beneficiaries listed will make it difficult to pay the benefit to the correct person in case it is ever needed.

* The value of employer-funded life insurance benefits in excess of $50,000 is taxable to you.

**Please review the full plan documents for plan details including exclusions and limitations.** This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

# Long-Term Disability

Madison National Life

If you become disabled due to a covered injury or illness, disability income benefits may provide a partial replacement of lost income.

Protecting your income is important! That is why you will be automatically enrolled in long-term disability coverage once eligible. To opt-out, please contact our Benefits Specialist.

| Long-Term Disability | |
|---|---|
| **Benefit Amount** | Replaces 66.67% of earnings |
| **Benefit Begins** | After a period of 90 days or end of sick leave |
| **Benefit Duration** | Up to Social Security normal retirement age (SSNRA) |

| | |
|---|---|
| **Long-Term Disability Cost** | Employer Provided |

**Actively-At-Work Requirement:**
New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-At-Work/eligible status.

**Please review the full plan documents for plan details including exclusions and limitations.** This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

# Supplemental Health

American Fidelity

The following benefits may protect your financial security in the event of an unexpected medical expense. You can use the payments however you like including out-of-pocket costs related to your care or even daily living expenses.

## Accident

Helps cover the cost of expenses if you are injured in a non-work-related, covered accident.

## Critical Illness/Cancer

Helps cover the cost of expenses if you are diagnosed with a covered condition.

## Hospital Indemnity

Helps cover the cost of hospital stays.

| Supplemental Health Cost | To view your personalized rates, log in to American Fidelity. |
|---|---|

**For plan coverage details, limitations, exclusions, and eligibility requirements contact American Fidelity.**

In addition to the supplemental health benefits, the following life insurance products are also available through American Fidelity:

- Term life insurance
- Term 100 life insurance
- Whole life insurance

# Discount Program

PerkSpot through our partnership with Cottingham & Butler

This program provides you access to an online marketplace that delivers thousands of discounts for everyday business and personal purchases, leveraging the purchasing power of some of the largest employers in the United States.

| Discount Program | | | |
|---|---|---|---|
| **Shop for a Variety of Coupons & Deals from these Categories:** | Apparel<br>Auto Buying<br>Automotive<br>Beauty & Fragrance<br>Books, Movies, & Music<br>Business Perks<br>Cell Phones<br>Education<br>Electronics<br>Financial Wellness<br>Flowers & Gifts<br>Food<br>Health & Wellness<br>Hobbies & Creative Arts | Home & Garden<br>Home Services<br>Insurance & Protection Services<br>Jewelry & Watches<br>Movie Tickets<br>Office & Business<br>Pets<br>Real Estate & Moving Services<br>Sports & Outdoors<br>Tickets & Entertainment<br>Toys, Kids & Babies<br>Travel | |
| **Popular Discounted Brands*** | Avis<br>Canon<br>Casper<br>Columbia | Dell<br>Enterprise<br>Holiday Inn | Home Chef<br>HP<br>Ray-Ban |
| **Benefit Cost** | Included in our partnership with Cottingham & Butler | | |

* All brands and discounts available are subject to change. For a current listing of discounts and brands offered visit the website at https://cottinghambutler.perkspot.com.

**Unlock discounts for you and your family!**

Visit: https://cottinghambutler.perkspot.com

## Who is PerkSpot?

- Online savings resource for employees
- Headquartered in Chicago, IL – Founded in 2006
- 750+ clients nationwide, 15 million members
- 30,000+ discount offers

## Website Features

- Recommended for You: chosen based on your top interests
- Featured Offers: hand-selected to help you stretch your dollars
- Today's Perk Alters: today's best limited-time sales
- Popular Savings: trending offers
- Categories: shop by category
- Local Discounts: shop by location

# Healthcare Tips

## Get the Most Out of Your Care

Knowing the difference between an in-network and out-of-network provider can save you a lot of money.

- **In-Network Provider**—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.
- **Out-of-Network Provider**—A provider who is not contracted with your health insurance company.

Calling the physician directly and double-checking with your insurance company is the best way to ensure that the provider is in-network. If you are receiving surgery, make sure to ask if the service is completely in-network. Often times, things such as anesthesia are not covered even though the primary physician is in-network.

**Where Should I Go for Care?**
www.cbmicrosite.com/video/knowwheretogo

## Billing & Claim Differences

Because in-network and out-of-network providers are treated differently by your insurance company, you will be billed differently depending on the type of provider you use for your care.

| | | | | |
|---|---|---|---|---|
| **Provider**<br>The patient receives treatment.<br>The doctor then sends the bill to the insurance company. | > | **In-Network Discount**<br>Appropriate discount for using an in-network provider is applied. | > | **Bill**<br>The bill for services is presented to the insurance company.<br>Payment responsibilities are calculated and divided between the patient and the insurance company. |
| | | | | v |
| **Patient**<br>Patient pays doctor's office for copayments, deductibles and/or coinsurance that he or she is responsible for. | < | **Insurance Company Payments, Explanation of Benefits (EOB)**<br>Insurance pays for its portion of the bill from the provider.<br>A summary of charges and insurance payments is sent to the patient via the insurance company. | | |

## Take advantage of preventive care

Preventive care is a type of health care whose purpose is to shift the focus of health care from treating sickness to maintaining wellness and good health. This includes a variety of health care services, such as a physical examination, screenings, laboratory tests, and immunizations.

Preventive care also helps lower the long-term cost of managing disease because it helps catch problems in the early stages when most diseases are more readily treatable. The cost of early treatment or diet or lifestyle changes is less than the cost of treating and managing a full-blown chronic disease or serious illness.

# Know Where to Go for Care

Keeping your health care costs in check could be as simple as making the right choice when you need medical care. When you have an illness or suffer an injury, you understandably want to feel better fast, but making the wrong choice about where to receive care can cost you.

The average outpatient emergency room (ER) visit costs $1,917, according to the Health Care Cost Institute. This means that if you head to the ER when you don't really need emergency care, your wallet is going to feel the pain.

## Where Should I Go?

Sometimes, it can be difficult to know where to draw the line when it comes to choosing if you should go to the ER, urgent care, or your primary doctor. Here are a few guidelines to help you know where to go next time you're sick or injured.

### Emergency Room ($$$$)

A visit to the ER is the most expensive type of outpatient care and should only occur if there is a true emergency, or a life-threatening illness or injury. Examples of conditions that should be addressed in the ER include, but aren't limited to:

- Chest pain
- Shortness of breath
- Uncontrollable bleeding
- Poisoning

**Where Should I Go for Care?**
www.cbmicrosite.com/video/knowwheretogo

### Urgent Care ($$$)

Urgent care centers handle non-emergency conditions that require immediate attention—those for which delaying treatment could cause serious problems or discomfort. Urgent care visits are less expensive than ER visits but are typically more expensive than a visit to your primary care doctor. These conditions can usually be treated in urgent care centers:

- Sprains
- Ear infections
- High fevers

### Doctor's Office ($$)

For most non-emergency illnesses or injuries, the best choice for medical care may be a visit to your primary care physician. Your regular doctor knows you best, has your medical history, and has the expertise to diagnose and treat most conditions. In addition, going to the doctor's office is usually the most cost-effective option.

METRO INTERAGENCY INSURANCE PROGRAM | Hinge Health

# Your partner for pain relief

**With Hinge Health, you can get virtual physical therapy and more from real people who are dedicated to helping you feel your best.**

## Specialized care, personalized for you

**Reduce everyday joint and muscle aches. Recover from an injury. Relieve pelvic pain and discomfort.**

- A care plan designed for your everyday activities and long-term goals — and to treat multiple areas of your body at once
- Access exercise therapy sessions you can do in as little as 15 minutes — anytime, anywhere with the Hinge Health app
- Get 1-on-1 support from a physical therapist or health coach to tailor your sessions as needed and help you reach your goals
- Access to Hinge Health Enso® a non-addictive, FDA-cleared wearable device to calm and soothe pain flare-ups in minutes


**Scan the QR code or visit:**

**hinge.health/miip-join**

Please use the default camera on your device to scan the QR code, not a third-party application. If you are directed to a site other than the URL listed above, do not proceed.

A HINGE HEALTH EXCLUSIVE

**Meet Enso**

The small device for pain relief on-the-go.

Eligibility to receive Hinge Health Enso is based on the program you are placed in, fulfillment of clinical eligibility criteria, and completion of a qualifying number of exercise therapy sessions.

Members and dependents 18+ enrolled in a MIIP medical plan, including the HDHP Value Plan, are eligible at no additional cost.

Los usuarios y dependientes mayores de 18 años inscritos en un plan médico de MIIP, incluido el plan de valor HDHP, son elegibles sin costo adicional.

Wellmark | Wellbeats Wellness

# Welcome to Wellbeats

**Free to you through your employer-sponsored health plan, administered by Wellmark® Blue Cross® and Blue Shield®.**

Wellbeats® *Wellness*, a product of LifeSpeak Inc., is an on-demand video streaming platform with high quality, expert-led fitness, nutrition, and mindfulness classes you can play on your personal devices anytime, anywhere.

**WHAT'S INCLUDED:**

- 1,200+ fitness, nutrition, and mindfulness classes for all ages, levels, abilities, and interests
- Classes such as yoga, strength training, HIIT, running/walking, meditation, mental wellness, healthy recipes, cycling, kickboxing, kids activities, and cooking education
- Goal-based programs with guided plans to keep you on track such as Get Started, Train Your Way to a 5K, Lose Weight, Build Strength, Daily Mobility, Healthy Back, Stress Less, and Nourish Your Everyday
- Short stretch breaks and exercises to recharge during the day
- Personalized class and program recommendations
- Personal statistics and automated reminders
- Social features to schedule classes, invite others to join, and chat in real time

WATCH NOW: Wellbeats in action

## How to Get Started:

1. Register/log in to myWellmark.com, then select **Well-being** from the menu
2. Select **Visit Wellmark Connect**; if a new window pops up choose **Continue**. Click the **Wellbeats** card.
3. Create a Wellbeats account, then **download the Wellbeats app** for quick access moving forward.

**Scan to activate your Wellbeats account!**

College Community School District

**Plan Year**
7/1/2026 - 6/30/2027

# Reviewed your benefits lately?

Enrolling in the same plans as last year may seem like the easiest way to go. But things change. The right benefits can help you be more financially stable and reviewing them regularly ensures you have the coverage you need.

Your American Fidelity account manager can help you pick the best options to meet your needs.

## Limited Benefit Accident Only Insurance

- Helps with out-of-pocket expenses for the treatment of covered accidental injuries.
- Provides benefit payments directly to you.
- Some covered accidents include burns, a sprained ankle or spider bites.

**Learn more: americanfidelity.com/accident**

## Disability Income Insurance

- Helps protect your finances in case of a covered injury or illness.
- Provides a benefit to help cover costs while you are unable to work.
- Select from custom coverage options.

**Learn more: americanfidelity.com/disability**

## Limited Benefit Cancer Insurance

- May help protect you financially if you are diagnosed with a covered cancer so you can focus on recovery.
- Provides benefit payments directly to you.
- May cover expenses like travel and lodging, experimental treatments and second opinions.

**Learn more: americanfidelity.com/cancer**

## Life Insurance

- May help financially protect your family if you were to pass away.
- Several plans available to select the coverage that best fits you and your family.
- Provides immediate coverage.

**Learn more: americanfidelity.com/life**

Learn more about your benefits.

https://enroll.americanfidelity.com/B2237CF7

AMERICAN FIDELITY
a different opinion


## 24/7 Access with AFmobile®

Manage your insurance benefits and reimbursement accounts all from the palm of your hand.

- **View** account balances
- **Manage** claims and reimbursements
- **Submit** documentation
- **Receive** alerts
- **Maintain** personal information

## Get Started:

**Register online** at **americanfidelity.com/register**

**Download AFmobile** at **americanfidelity.com/afmobile**

*Please allow one business day after you enroll before registering for an online account. If you already have an account, your username and password will be the same for AFmobile.*

## Did your salary increase?

If your salary has increased since your last enrollment, it's important that you review your **Disability Income Insurance** coverage.

Help protect more of your paycheck and your lifestyle by ensuring you have the coverage you need.

**americanfidelity.com/disability-increase**

*These products may contain limitations, exclusions, and waiting periods. The following statements only apply if the product is displayed on this document.* ***These products are not appropriate for people who are eligible for Medicaid coverage: Accident Only, Cancer, Critical Illness, Hospital Indemnity, Hospital GAP PLAN® and Hospital GAP Plan Choice® Insurance.*** *Variable Annuities are offered by American Fidelity Securities, Inc., a registered Broker Dealer. Please contact your tax advisor for information regarding your specific situation. HSA contributions are not subject to federal and most states' income tax. State income tax may apply in California and New Jersey. Please consult a tax advisor for your state's specific rules. HRAs are not part of a Section 125 Plan. Contributions made by employer not employee.*

American Fidelity Assurance Company
**americanfidelity.com**

Kansas Branch
**800-365-1167 • 785-232-8100**

AF-2150-0823

# Benefit Terms

The world of health insurance has many terms that can be confusing. Understanding your costs and benefits—and estimating the price of a visit to the doctor—becomes much easier once you are able to make sense of the terminology.

## Definitions

- **Annual limit**—Cap on the benefits your insurance company will pay in a given year while you are enrolled in a particular health insurance plan.
- **Claim**—A bill for medical services rendered.
- **Cost-sharing**—Health care provider charges for which a patient is responsible under the terms of a health plan. This includes deductibles, coinsurance and copayments.
- **Coinsurance**—Your share of the costs of a covered health care service calculated as a percentage of the allowed amount for the service.
- **Copayment (copay)**—A fixed amount you pay for a covered health care service, usually when you receive the service.
- **Deductible**—The amount you owe for health care services each year before the insurance company begins to pay. Example: John has a health plan with a $1,000 annual deductible. John falls off his roof and has to have three knee surgeries, the first of which is $800. Because John hasn't paid anything toward his deductible yet this year, and because the $800 surgery doesn't meet the deductible, John is responsible for 100 percent of his first surgery.
- **Dependent Coverage**—Coverage extended to the spouse and children of the primary insured member. Age restrictions on the coverage may apply.
- **Explanation of Benefits (EOB)**—A statement sent from the health insurance company to a member listing services that were billed by a provider, how those charges were processed and the total amount of patient responsibility for the claim.
- **Group Health Plan**—A health insurance plan that provides benefits for employees of a business.
- **In-network Provider**—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.
- **Inpatient Care**—Care rendered in a hospital when the duration of the hospital stay is at least 24 hours.
- **Insurer (carrier)**—The insurance company providing coverage.
- **Insured**—The person with the health insurance coverage. For group health insurance, your employer will typically be the policyholder and you will be the insured.
- **Open Enrollment Period**—Time period during which eligible persons may opt to sign up for coverage under a group health plan.
- **Out-of-network Provider**—A provider who is not contracted with your health insurance company.
- **Out-of-pocket Maximum (OOPM)**—The maximum amount you should have to pay for your health care during one year, excluding the monthly premium. After you reach the annual OOPM, your health insurance or plan begins to pay 100 percent of the allowed amount for covered health care services or items for the rest of the year.
- **Outpatient Care**—Care rendered at a medical facility that does not require overnight hospital admittance or a hospital stay lasting 24 hours or more.
- **Policyholder**—The individual or entity that has entered into a contractual relationship with the insurance carrier.
- **Premium**—Amount of money charged by an insurance company for coverage.
- **Preventive Care**—Medical checkups and tests, immunizations and counseling services used to prevent chronic illnesses from occurring.
- **Provider**—A clinic, hospital, doctor, laboratory, health care practitioner or pharmacy.
- **Qualifying Life Event**—A life event designated by the IRS that allows you to amend your current plan or enroll in new health insurance. Common life events include marriage, divorce, and having or adopting a child.
- **Qualified Medical Expense**—Expenses defined by the IRS as the costs attached to the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body.
- **Summary of Benefits and Coverage (SBC)**—An easy-to-read outline that lets you compare costs and coverage between health plans.

## Acronyms

- **ACA**—Affordable Care Act
- **CDHC**—Consumer driven or consumer directed health care
- **CDHP**—Consumer driven health plan
- **CHIP**—The Children's Health Insurance Program. A program that provides health insurance to low-income children, and in some states, pregnant women who do not qualify for Medicaid but cannot afford to purchase private health insurance.
- **CPT Code**—Current procedural terminology code. A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities, such as physicians, health insurance companies and accreditation organizations.
- **FPL**—Federal poverty level. A measure of income level issued annually by the Department of Health and Human Services (HHS) and used to determine eligibility for certain programs and benefits.
- **FSA**—Flexible spending account. An employer-sponsored savings account for health care expenses.
- **HDHP**—High deductible health plan
- **HMO**—Health maintenance organization
- **HRA**—Health reimbursement arrangement. An employer-funded arrangement that reimburses employees for certain medical expenses.
- **HSA**—Health savings account. A tax-advantaged savings account that accompanies HDHPs.
- **OOP**—Out-of-pocket limit. The maximum amount you have to pay for covered services in a plan year.
- **PCE**—Pre-existing condition exclusion. A plan provision imposing an exclusion of benefits due to a pre-existing condition.
- **PPO**—Preferred provider organization. A type of health plan that contracts with medical providers (doctors and hospitals) to create a network of participating providers. You pay less when using providers in the plan's network, but can use providers outside the network for an additional cost.
- **QHP**—Qualified health plan. A certified health plan that provides an essential health benefits package. Offered by a licensed health insurer.

# College Community School District Group Health Plan: Important Disclosures & Notices

## Michelle's Law Notice

If the Plan provides for dependent coverage that is based on a dependent's full-time student status, then this Michelle's Law Notice applies. If there is a medically necessary leave of absence from a post-secondary educational institution or other change in enrollment that: (1) begins while a dependent child is suffering from a serious illness or injury; (2) is certified by a physician as being medically necessary; and (3) causes the dependent child to lose student status for purposes of coverage under the plan, that child may maintain dependent eligibility for up to one year. If the treating physician does not provide written documentation when requested by the Plan Administrator that the serious illness or injury has continued, making the leave of absence medically necessary, the plan will no longer provide continued coverage. ❖

## Benefits during a Leave of Absence

Your health benefits may be protected and maintained during a leave of absence, such as a leave qualifying under the Family Medical Leave Act. Other leaves of absence may, however, render you ineligible to participate in the health plan. If coverage is lost due to a leave of absence, you may be eligible to continue coverage under COBRA. Similarly, if you become ineligible for health benefits due to a leave of absence for military reasons, you may be eligible to continue that coverage under USERRA. Please contact your Human Resources Department or your manager for more information regarding what benefits are protected and maintained during a leave of absence and for more information about FMLA, COBRA and USERRA. ❖

## Premium Assistance under Medicaid and The Children's Health Insurance Program (CHIP)

If an Employee or an Employee's children are eligible for Medicaid or CHIP and are eligible for health coverage from an employer, the state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If the Employee or his/her children are not eligible for Medicaid or CHIP, they will not be eligible for these premium assistance programs but they may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If an Employee or his/her dependents are already enrolled in Medicaid or CHIP and they live in a State listed below, they may contact the State Medicaid or CHIP office to find out if premium assistance is available.

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

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

**Employees living in one of the following States may be eligible for assistance paying employer health plan premiums. The following list of States is current as of January 31, 2026. V 0.7.1.**
**The most recent CHIP notice can be found at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra. Contact the respective State for more information on eligibility –**

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

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

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

**CALIFORNIA – Medicaid**
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+)**
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+ Website: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service:
1-800-359-1991/State Relay 771
Health Insurance Buy-In Program (HIBI) Website:
https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

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

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

**INDIANA – Medicaid**
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)**
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

**KANSAS – Medicaid**
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

**KENTUCKY – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/

kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website:
https://chfs.ky.gov/agencies/dms

**LOUISIANA – Medicaid**
Website: https://www.ldh.la.gov/healthy-louisiana
Medicaid Customer Service Line: 1-888-342-6207
Louisiana Medicaid email: healthy@la.gov
Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp
LaHIPP phone: 1-877-697-6703
LaHIPP email: La.HIPP@la.gov
LaHIPP fax: 1-888-716-9787
LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084

**MAINE – Medicaid**
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

**MASSACHUSETTS – Medicaid and CHIP**
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

**MINNESOTA – Medicaid**
Website:
https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

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

**MONTANA – Medicaid**
Website: https://dphhs.mt.gov/MontanaHealthcarePrograms/MemberServices
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

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

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

**NEW HAMPSHIRE – Medicaid**
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program:
1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

**NEW JERSEY – Medicaid and CHIP**
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)

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

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

**NORTH DAKOTA – Medicaid**
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

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

**OREGON – Medicaid**
Website:
http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

**PENNSYLVANIA – 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)

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

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

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

**TEXAS – Medicaid**
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

**UTAH – Medicaid and CHIP**
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**
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

**VIRGINIA – Medicaid and CHIP**
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

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

**WEST VIRGINIA – Medicaid and CHIP**
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**
Website: https://www.dhs.wisconsin.gov/medicaid/index.htm
Phone: 1-800-362-3002

**WYOMING – Medicaid**
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 January 31, 2026, 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 ❖

## Patient Protection Notice

If the College Community School District Group Health Plan 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. If the plan or health insurance coverage designates a primary care provider automatically, you will be able to designate a new provider. For information on how to select a primary care provider, and for a list of

the participating primary care providers, contact Human Resources. ❖

## Women's Health and Cancer Rights Act of 1998

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.
- 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. ❖

## Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers offering group health insurance coverage 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 normal 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 or 96 hours, as applicable. Additionally, no group health plan or issuer may require that a provider obtain authorization from the Plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). ❖

## New Health Insurance Marketplace Coverage Options and Your Health Coverage

**PART A: General Information**
When key parts of the health care law took effect in 2014, a new way to buy health insurance became available: the Health Insurance Marketplace. To assist Employees as they evaluate options for themselves and their family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by their employer.

**What is the Health Insurance Marketplace?**
The Marketplace is designed to help individuals and families find health insurance that meets their needs and fits their budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. Employees may also be eligible for a new kind of tax credit that lowers their monthly premium right away. The open enrollment period for health insurance coverage through the Marketplace began on Nov. 1st, and ended on Dec. 15. Individuals must have enrolled or changed plans prior to Dec. 15, for coverage starting as early as Jan. 1st. After Dec. 15th, individuals can get coverage through the Marketplace only if they qualify for a special enrollment period.

**Can individuals Save Money on Health Insurance Premiums in the Marketplace?**
Individuals may qualify to save money and lower monthly premiums, but only if their employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on premiums depends on household income.

**Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?**
Yes. If the Employee has an offer of health coverage from his/her employer that meets certain standards, they will not be eligible for a tax credit through the Marketplace and may wish to enroll in their employer's health plan. However, an individual may be eligible for a tax credit that lowers their monthly premium, or a reduction in certain cost-sharing if their employer does not offer coverage at all or does not offer coverage that meets certain standards. If the cost of a plan from an employer that would cover the Employee (and not any other members of their family) is more than 9.96% of household income for the plan year beginning in 2026, or if the coverage the employer provides does not meet the "minimum value" standard set by the Affordable Care Act, the Employee may be eligible for a tax credit.*

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

**How Can Individuals Get More Information?**
For more information about coverage offered by the Employer, please check the summary plan description or contact Human Resources.

The Marketplace can help when evaluating coverage options, including 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 the area.

* 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% of such costs. ❖

## Special Enrollment Rights

If an employee declines enrollment for him/herself or for their dependents (including their spouse) because of other health insurance coverage, they may be able to enroll him/herself or their dependents in this Plan in the future, provided they request enrollment within 30 days after their other coverage ends. Coverage will begin under this Plan no later than the first day of the first month beginning after the date the plan receives a timely request for enrollment.

If an employee acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption, they may be able to enroll him/herself and their dependents provided that they request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If an employee adds coverage under these circumstances, they may add coverage mid-year. For a new spouse or dependent acquired by marriage, coverage is effective no later than the first day of the first month beginning after the date the plan receives a timely request for the enrollment. When a new dependent is acquired through birth, adoption, or placement for adoption, coverage will become effective retroactive to the date of the birth, adoption, or placement for adoption. The plan does not permit mid-year additions of coverage except for newly eligible persons and special enrollees.

**Individuals gaining or losing Medicaid or State Child Health Insurance Coverage (SCHIP)**
If an employee or their dependent was:

1. covered under Medicaid or a state child health insurance program and that coverage terminated due to loss of eligibility, or
2. becomes eligible for premium assistance under Medicaid or state child health insurance program, a special enrollment period under this Plan will apply.

The employee must request coverage under this Plan within 60 days after the termination of such Medicaid or SCHIP, or within 60 days of becoming eligible for the premium assistance from Medicaid or the SCHIP. Coverage under the plan will become effective on the date of termination of eligibility for Medicaid/state child health insurance program, or the date of eligibility for premium assistance under Medicaid or SCHIP. ❖

# HIPAA Notice of Privacy Practices

***THIS NOTICE DESCRIBES HOW INDIVIDUAL MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW TO GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.***

**HIPAA Notice of Privacy Practices**
This Notice of Privacy Practices (the "Notice") describes the legal obligations of the College Community School District Group Health Plan (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

and the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information (PHI) is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to:

a. Your past, present, or future physical or mental health or condition;
b. The provision of health care to you; or
c. The past, present, or future payment for the provision of health care to you.

We are required by law to:

a. maintain the privacy of your PHI;
b. provide you with certain rights with respect to your PHI;
c. provide you with a copy of this Notice of our legal duties and privacy practices with respect to your PHI; and
d. follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your PHI that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices.

**HOW THE PLAN MAY USE AND DISCLOSE YOUR PHI**

Under the law, we may use or disclose your PHI under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your PHI. Not every use or disclosure in a category will be listed. Note that we will use and disclose PHI as described below unless otherwise prohibited or restricted by applicable state or other law, and that information can lose its protected status as PHI once re-disclosed by a recipient:

**1. For Treatment:** When and as appropriate, we may use or disclose medical information about you to facilitate medical treatment or services by health care providers. For example, we might disclose information about you with physicians who are treating you.

**2. For Payment:** We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or pre-certification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

**3. For Health Care Operations:** We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. However, we will not use your genetic information for underwriting purposes.

**4. To Plan Sponsors:** For the purpose of administering the plan, we may disclose PHI to certain employees of the Employer. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

**5. To Business Associates**: We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your PHI, but only after they agree in writing with us to implement appropriate safeguards regarding your PHI by entering into a Business Associate Agreement with us.

**6. Substance Use Disorder (SUD) Treatment Information**: Some of your health information may be part of a SUD patient record and subject to additional protections under federal law (42 CFR Part 2) governing confidentiality of SUD patient records.

If we receive or maintain any information about you from a SUD treatment program that is covered by 42 CFR Part 2 (a “Part 2 Program”) through a general consent you provide to the Part 2 Program to use and disclose the SUD patient record for purposes of treatment, payment or health care operations, we may use and disclose your SUD patient record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your SUD patient record through specific consent you provide to us or another third party, we will use and disclose your SUD patient record only as expressly permitted by you in your consent as provided to us. In no event will we use or disclose your SUD patient record, or testimony that describes the information contained in your SUD patient record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or

local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

**7. As Required by Law:** We will disclose your PHI when required to do so by federal, state, or local law. For example, we may disclose your PHI when required by national security laws or public health disclosure laws.

**8. Health Oversight Activities:** We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**9. Threats to Health or Safety:** We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your PHI in a proceeding regarding the licensure of a physician.

**10. Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

**11. Law Enforcement Purposes:** We may disclose your PHI if asked to do so by a law-enforcement official:

a. in response to a court order, subpoena, warrant, summons, or similar process;
b. to identify or locate a suspect, fugitive, material witness, or missing person;
c. about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
d. about a death that we believe may be the result of criminal conduct; and
e. about criminal conduct.

**12. Coroners, Medical Examiners, or Funeral Directors:** For the purpose of identifying a deceased person, we may release PHI to identify a deceased person or to determine a cause of death or other duties as authorized by law.

**13. Organ or Tissue Donation:** If you are an organ donor, we may release your PHI after your death to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

**14. Military and National Security:** If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may release your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

**15. Workers' Compensation:** We may release your PHI for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

**16. Treatment Alternatives or Health-Related Benefits and Services:** We may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

**17. Government Required Disclosures**: We are required to disclose your PHI to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

**Authorizations:** Other uses or disclosures of your PHI not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your PHI for marketing; and we will not sell your PHI, unless you give us a written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

**HOW THE PLAN MAY USE AND DISCLOSE YOUR PHI**

Under the law, we may use or disclose your PHI under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your PHI. Not every use or disclosure in a category will be listed. Note that we will use and disclose PHI as described below unless otherwise prohibited or restricted by applicable state or other law, and that information can lose its protected status as PHI once re-disclosed by a recipient:

We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person.

To request restrictions, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply-for example, disclosures to your spouse.

**Right to Inspect and Copy:** You have the right to inspect and copy certain PHI that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if possible. If

we cannot agree on an electronic form and format, or you request a paper copy, we will provide you with a paper copy. We may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

To inspect and copy your PHI, you must submit your request in writing. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request.

**Right to Amend:** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing. In addition, you must provide a reason that supports your request.

**Right to an Accounting of Disclosures:** You have the right to request an "accounting" of certain disclosures of your PHI. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. There may be a charge for the cost of providing lists beyond the last 12-month period.

**Right to Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing. Your request must specify how or where you wish to be contacted, but you do not have to provide a reason for your request. We will accommodate all reasonable requests.

**Right to a Paper Copy of this Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

**Right to be Notified of a Breach:** You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured PHI.

**Contact Information and Complaints:** If you have any questions about this Notice or about our privacy practices, and for any correspondence or requests related to the contents of this Notice, please contact College Community School District, 401 76th Ave SW, Cedar Rapids, IA 52404. (319) 848-5200.

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact the person listed in the Contact Information section of this Notice. All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us. ❖

## Important Notice from College Community School District Group Health Plan about Your Prescription Drug Coverage and Medicare (Creditable Coverage)

## For HMO Core, PPO Core, and PPO Choice Plans

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with College Community School District and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or

join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

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

**When Can You Join A Medicare Drug Plan?**
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

**What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?**
If you decide to join a Medicare drug plan, your current College Community School District coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current College Community School District coverage, be aware that you and your dependents will be able to get this coverage back.

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

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

**For More Information about this Notice or Your Current Prescription Drug Coverage**
Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through College Community School District changes. You also may request a copy of this notice at any time.

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: March 25, 2026
Name of Entity/Sender: College Community School District
Contact--Position/Office: Human Resources
Address: [EMPLOYER ADDRESS]
Phone Number: (319) 848-5200 ❖

## Important Notice from College Community School District Group Health Plan about Your Prescription Drug Coverage and Medicare (Non-Creditable Coverage)

## For HDHP Value Plan

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with College Community School District and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to

everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. College Community School District Group Health Plan has determined that the prescription drug coverage offered by College Community School District is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the College Community School District Group Health Plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can keep your current coverage from College Community School District. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

**When Can You Join A Medicare Drug Plan?**
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you decide to drop your current coverage with College Community School District , since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under the College Community School District Group Health Plan.

**When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?**
Since the coverage under the College Community School District Group Health Plan, is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

**What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?**
If you decide to join a Medicare drug plan, your current College Community School District coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current College Community School District coverage, be aware that you and your dependents will be able to get this coverage back.

**For More Information about this Notice or Your Current Prescription Drug Coverage**
Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through College Community School District changes. You also may request a copy of this notice at any time.

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

For more information about Medicare prescription drug coverage:

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

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

Date: March 25, 2026
Name of Entity/Sender: College Community School District
Contact--Position/Office: Human Resources
Address: 401 76th Ave SW, Cedar Rapids, IA 52404
Phone Number: (319) 848-5200 ❖