



**MUSCATINE**  
COMMUNITY SCHOOL DISTRICT

# BENEFITS GUIDE

# 2026





# WHAT'S INSIDE

<b>GETTING STARTED</b> .....	3
• Coverage and Eligibility	
• Insurance Premiums	
<b>BODY AND MIND</b> .....	5
• Medical Benefits	
• Virtual Visits	
• Dental	
• Vision	
<b>FUNDING ACCOUNTS</b> .....	10
• Health Savings Account (HSA)	
• Flexible Spending Account (FSA)	
<b>INCOME PROTECTION</b> .....	12
• Life Insurance	
• Long-Term Disability	
<b>OTHER BENEFITS</b> .....	13
• Critical Illness	
• Individual Term Life	
• Individual Whole Life	
• Cancer	
• Accident Coverage	
• FedLogic	
<b>CONTACTS</b> .....	15
<b>REQUIRED NOTICES</b> .....	16

## WELCOME TO YOUR BENEFITS!

We are committed to providing competitive benefit programs that are flexible enough to meet your individual needs, as well as your family's needs.

Our comprehensive benefits are carefully designed to give you the tools you need to keep you and your family healthy, provide financial protection in the event of unforeseen circumstances and help you build long-term security for retirement.

As always, we encourage you to prioritize your well-being by focusing on preventive care and the tools and resources available to help you live your best life.

Before you make your benefit elections, take the time to review this guide so you can make an informed decision on which plans are the right fit for you and your family. Remember to choose wisely; the choices you make during Open Enrollment cannot be changed until the following year unless you have a qualifying life event.

This guide provides a summary of plan highlights. This is not a binding contract. In the event of any difference between the information contained herein and the plan documents, the plan documents will supersede and control over this guide. Please consult the Summary Plan Description for information on covered charges, limitations, and exclusions.

### **INITIAL ENROLLMENT:**

If you are a full-time employee scheduled to work 20 or more hours per week, you are eligible to enroll in the benefits described in this guide. New hires are effective 1st of the month following date of hire.

### **ANNUAL OPEN ENROLLMENT:**

The annual open enrollment period is typically held in May.

### **ENROLLING:**

To enroll, make an appointment with an American Fidelity representative. Visit [americanfidelity.com/muscatinecsdc](https://americanfidelity.com/muscatinecsdc) for more information

### **COVERING YOUR DEPENDENTS**

- Legal Spouse
- Child(ren) (up to age 26), including biological, adopted, stepchildren, legal guardianship, and disabled children if disabled prior to age 26 and are dependent on you for support

### **QUALIFYING LIFE EVENTS**

The benefits you elect during enrollment are in effect through June 30, 2027, so choose your coverage carefully.

You can only make changes outside of enrollment if you have a qualifying life event, such as:

- Gain or loss of dependent status (i.e., your child reaches the age limit for eligibility)
- Change in legal marital status, including marriage, divorce, or death of a spouse
- Change in employment status, such as starting or ending employment, for you, your spouse, or your children
- End of the maximum period for COBRA coverage
- Loss of other coverage

# **COVERAGE & ELIGIBILITY**



# INSURANCE PREMIUMS

Medical			
	\$500 Traditional POS	\$750 Traditional PPO	High Deductible Health Plan
Single	\$938.00	\$1,004.00	\$821.00
Employee + 1	\$1,779.00	\$1,904.00	\$1,555.00
Family	\$2,827.00	\$3,025.00	\$2,468.00

Dental	
Single	\$35.00
Family	\$110.00

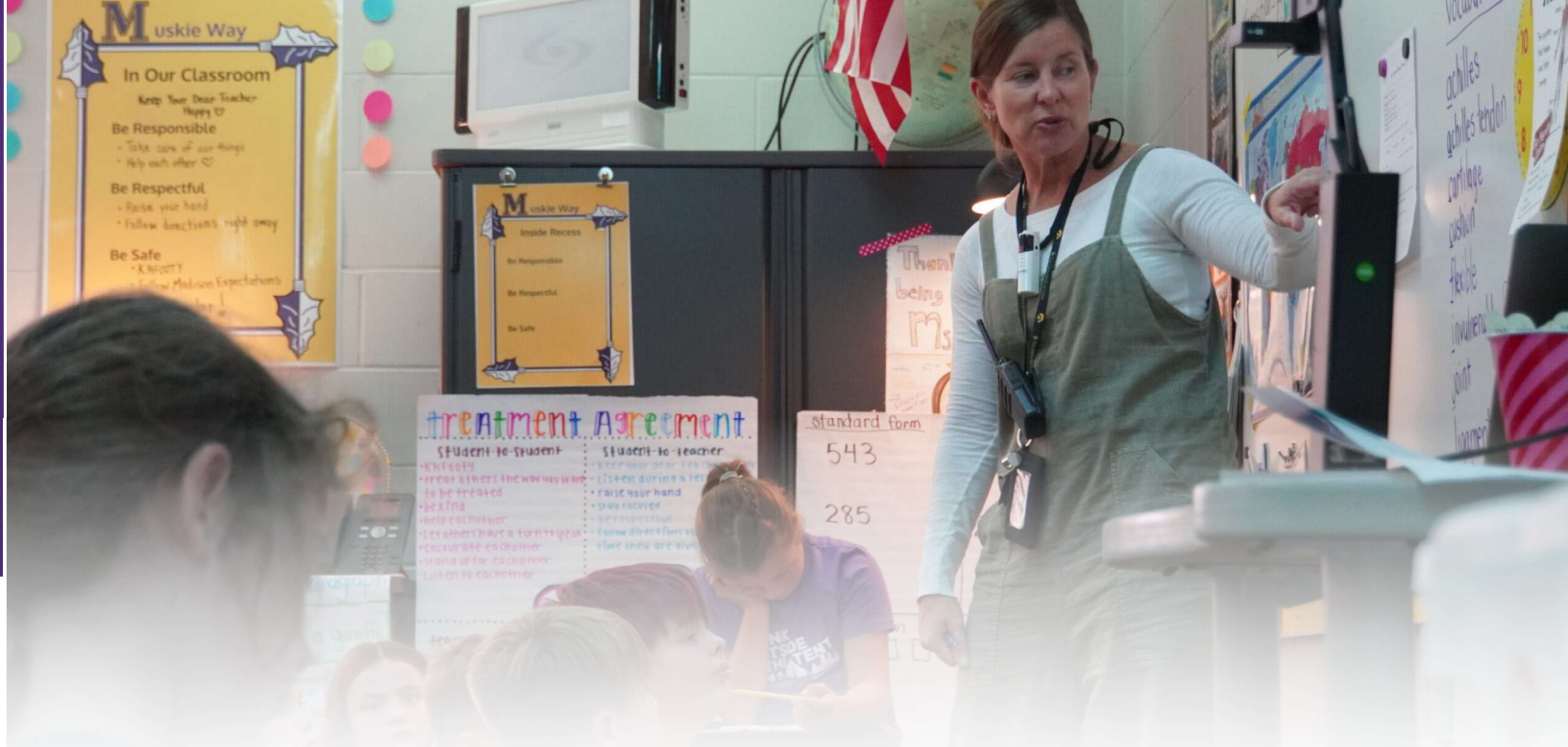
Vision	
Employee Only	\$9.83
Employee + Spouse	\$15.73
Employee + Child(ren)	\$16.05
Employee + Family	\$25.88

Voluntary Benefits	
Rates Vary	

Voluntary Life & AD&D: Rates Per \$10,000		
Age Bands	Employee	Spouse
Under 30	\$1.00	\$0.50
30-34	\$1.20	\$0.60
35-39	\$1.50	\$0.75
40-44	\$2.20	\$1.10
45-49	\$3.40	\$1.70
50-54	\$5.50	\$2.75
55-59	\$8.30	\$4.15
60-64	\$13.00	\$6.50
65-69	\$23.90	\$11.95
70-74	\$39.20	\$19.60
75+	\$63.40	\$31.70
Children (per family)	\$2.00	

## Need More Information?

Contact Marsha Shingledecker in the Benefits Department at 563-263-7223



# MEDICAL BENEFITS



It's important to have choices when it comes to healthcare.

That's why Muscatine CSD

offers three medical plan options—a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), a \$500 Traditional Point of Service (POS) Plan, and a \$750 Traditional PPO plan—designed to give you choice in cost, control, and coverage level. All plans are offered by Wellmark. The PPO plans include providers nationwide as in-network while the POS plan's network is more narrow, Iowa-based.



## Preventive Care: Your Key to Wellness

Identifying potential problems before they become major issues is key to your health.

All medical plans include free in-network preventive care that includes annual physicals, mammograms, well child visits, immunizations, and more. Stay on top of your wellness and schedule your in-network preventive visit today!

## CONSIDER YOUR COVERAGE

When choosing between the plans, it all comes down to how much you want to spend from your paycheck and whether you are comfortable with lower or higher out-of-pocket expenses and deductibles when you need care.

- The High-Deductible Health Plan (HDHP) is a good option if you want the lowest payroll premiums and are comfortable with higher out-of-pocket costs and a higher deductible when you need care. With this plan, you may contribute to a Health Savings Account (HSA) and a Limited Purpose Flexible Spending Account (FSA) for eligible dental and vision expenses, allowing you to use pre-tax dollars for qualified healthcare costs.
- The \$500 Traditional POS plan offers a middle-ground option with moderate payroll premiums and moderate out-of-pocket costs. This plan includes predictable copays for office visits and prescription drugs and provides coverage within the Iowa-only network. Out-of-network care is available if needing to seek care outside of Iowa.
- The \$750 Traditional PPO plan is ideal if you prefer higher payroll premiums in exchange for the comfort of being able to seek services nationwide at an in-network level.

Employees enrolled in the Traditional POS or Traditional Copay plan may contribute to a Flexible Spending Account (FSA) to pay for eligible medical, dental, and vision expenses with pre-tax dollars throughout the year. See the Funding Accounts page for more information on how you can plan to cover your cost of care.

### No matter which option you choose, all plans:

- Provide preventive care at 100%
- Provide prescription drug coverage
- Provide virtual care including mental health services at no cost through Doctor on Demand

## Medical Plans at a Glance

	\$500 Traditional POS	\$750 Traditional PPO	High Deductible Health Plan
	<b>IN-NETWORK (IOWA ONLY)</b>	<b>IN-NETWORK</b>	<b>IN-NETWORK</b>
<b>HSA Funding</b>	N/A	N/A	\$1,400 annually
<b>Deductible</b>	\$500 individual \$1,000 family	\$750 individual \$1,500 family	\$3,400 individual \$6,800 family
<b>Out-of-Pocket Maximum</b>	\$1,250 individual \$2,500 family	\$1,500 individual \$3,000 family	\$3,400 individual \$6,800 family
<b>YOU PAY</b>			
<b>Preventive Care</b>	No cost	No cost	No cost
<b>Office Visits</b>	\$5 designated PCP \$10 other PCP	\$10 copayment	Deductible
<b>Specialist Visits</b>	\$10 copayment	\$10 copayment	Deductible
<b>Doctor on Demand</b>	No cost	No cost	No cost
<b>Emergency Room</b>	Deductible waived, 20% coinsurance	Deductible waived, 20% coinsurance	Deductible
<b>Outpatient and Inpatient Services</b>	Deductible, 20% coinsurance	Deductible, 20% coinsurance	Deductible
<b>PRESCRIPTIONS - VIVIDCLEAR RX</b>			
<b>Out-of-Pocket Maximum</b>	\$1,750 single \$3,500 family	\$1,750 single \$3,500 family	Aggregates with Medical
<b>Prescriptions (30-Day Supply)</b>	Tier 1: \$10 Tier 2: \$30 Tier 3: \$45	Tier 1: \$10 Tier 2: \$30 Tier 3: \$45	Deductible
<b>Mail Order (90-Day Supply)</b>	3 copayments	3 copayments	Deductible
<b>Specialty Medications Amber Specialty Pharmacy</b>	Biosimilar: \$45 Preferred: \$85 Non-Preferred: \$125	Biosimilar: \$45 Preferred: \$85 Non-Preferred: \$125	Deductible

### Specialty Prescription Program

Specialty medications are outsourced through Amber Specialty Pharmacy. Certain specialty medications could be available at no cost through ScriptSourcing. Visit <https://script sourcing.com/med-finder> to confirm your medication's eligibility.

### Terms to Know

Benefits can be confusing! Here's a quick reference to help you navigate commonly used terms:

- **Copay:** A flat dollar amount you pay the provider when you receive a service.
- **Deductible:** The amount you pay for services before the plan begins paying some of the cost. The deductible may not apply to all services, including preventive care.
- **Coinsurance:** The portion of covered expenses you and the plan share after you meet the deductible (listed as a percentage).
- **Out-of-Pocket Maximum (OOP Max):** The maximum amount you pay out of your pocket for covered expenses in a year. Once you reach the out-of-pocket maximum, the medical plan pays for all covered services for the rest of the year.

# VIRTUAL VISITS



## Doctor on Demand

When you have a minor illness, the last thing you want to do is leave the comfort of home to sit in the doctor's office.

Virtual Visits with Doctor on Demand are available to employees enrolled in a medical plan and their covered family members. You can see a doctor 24 hours a day, seven days a week, 365 days a year.

Appointments can take place by webcam or a camera-equipped mobile device. Most visits take only 10 minutes and, in most cases, doctors can write a prescription for pick up at your local pharmacy.

Virtual Visits are \$0 for employees enrolled in any of Muscatine CSD's medical plans when using providers through Doctor On Demand.

## Getting Started is Easy

Download the Doctor on Demand app or visit [DoctorOnDemand.com/Wellmark](https://www.DoctorOnDemand.com/Wellmark)

- Have your Wellmark member ID card ready
- Create an account or sign in
- Call 800-997-6196 with any questions 24/7

## Know Before You Go

Staying in-network is the best way to keep your medical costs low. But did you also know that deciding where to go for care based on the type of treatment you need and how quickly you need it can also save you money?

If you're enrolled in one of the medical plans, the chart below can help you decide where to go for care based on the type of treatment you need, how much you can expect to spend, and how quickly you need it.

Type of Symptoms	Best Path for Care	Cost*	Average Wait Time	Hours of Operation
Common cold Flu Sinus infection Ear infections Mild Covid-19 Allergies UTI	Doctor on Demand	\$0	A few minutes	24/7
Basic health problems Chronic conditions Persistent joint pain	Primary Care Physician	\$	Wait times vary	Traditional office hours (appointment often required)
Minor cuts Burns Sprains Ear or sinus pain Minor allergic reactions Animal bites Broken bones	Urgent Care Clinic	\$\$	About an hour	Extended hours (includes evenings, weekends, and holidays)
Sudden numbness Uncontrolled bleeding Difficulty breathing Seizure Loss of consciousness Chest pain	Emergency Room	\$\$\$	A few hours	24/7

\*Cost is always lower when using in-network providers.

# DENTAL

In addition to protecting your smile, dental insurance helps pay for dental care and includes regular checkups, cleanings, and x-rays. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery. Dental coverage is offered for basic and major services. You and your eligible dependents may enroll in the dental coverage options administered by Delta Dental.

Plan Features	PPO Network	Premier Network
<b>Annual Deductible - Individual</b>	\$15	\$25
<b>Annual Deductible - Family</b>	\$25	\$75
<b>Annual Maximum</b>	\$1,250	
<b>Check-Ups &amp; Cleanings</b> <ul style="list-style-type: none"> <li>• Exams</li> <li>• Routine Cleanings</li> <li>• Fluoride Treatment</li> <li>• Space Maintainers</li> <li>• Routine X-rays</li> </ul>	Deductible waived, 0% coinsurance	
<b>Cavity Repair &amp; Extractions</b> <ul style="list-style-type: none"> <li>• Fillings</li> <li>• General Anesthesia/Sedation</li> <li>• Emergency Pain/Infection Relief</li> </ul>	Deductible, 10% coinsurance	Deductible, 20% coinsurance
<b>Root Canals &amp; Implants</b>	Deductible, 20% coinsurance	
<b>Major Services</b> <ul style="list-style-type: none"> <li>• Bridges</li> <li>• Dentures</li> <li>• Periodontal</li> </ul>	Deductible, 50% coinsurance	
<b>Orthodontia Lifetime Maximum</b> Children up to age 19	\$1,000 per child per lifetime	

## In-Network Provider

If you receive care from one of Delta Dental's preferred dentists, you'll pay less for your care. If you choose a non-preferred dentist, your share of costs will generally be higher and you may need to file your own claims. To find an in-network provider visit [www.deltadental.com/us/en/member/find-a-dentist.html](http://www.deltadental.com/us/en/member/find-a-dentist.html) select 'Delta Dental PPO Plus Premier.'



# VISION

Protect your vision—it’s one of your most precious assets. Whether you prefer contact lenses for a discreet look or stylish frames to make a statement, our vision plan has you covered. Your vision insurance is provided by VSP and entitles you to specific eye care benefits. Our policy covers routine eye exams and other procedures and provides specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses.

VSP Network	
<b>BENEFIT FREQUENCY</b>	
Contact Lenses or Lens	Once every 12 months
Exam	Once every 12 months
Frame	Once every 24 months
Vision Care Service	In-Network
<b>EXAM</b>	
Exam	\$10 copayment
Lasik or PRK Vision Corrections	15-20% off or 5% promotional offer for laser surgery
<b>LENS</b>	
Single Vision	\$25 copayment
Bi-focal	\$25 copayment
Tri-focal	\$25 copayment
Standard Progressive Lens	\$55 copayment
Specialty Lens	\$95 - \$175 copayment
<b>FRAME</b>	
Frame	Up to \$130 reimbursement
<b>CONTACTS</b>	
Elective (in lieu of glasses)	Up to \$130 reimbursement

**In-Network Provider**

To find an in-network provider visit [www.vsp.com](http://www.vsp.com).

Health Savings Accounts, Flexible Spending Accounts, and Dependent Care Accounts offer some of the most effective ways to save on healthcare and dependent care costs. These accounts let you set aside money for eligible expenses while reducing your taxable income through pre-tax contributions.



### HEALTH SAVINGS ACCOUNT (HSA)

You must enroll in the HDHP to be eligible to participate in the HSA. The HSA allows you to set aside pre-tax dollars into an account you own to pay for eligible healthcare expenses such as deductibles, coinsurance, and other out-of-pocket dental, vision, and prescription drug expenses not covered by a health plan.

You will elect your contribution limit during enrollment and can change it any time during the year. Your contributions will be deposited into your HSA each pay period, and funds are available for use as they are deposited. Your account balance will carry over from year to year, and you can take it with you if you leave Muscatine CSD.

### HSA at a Glance

	Total HSA Contribution Allowed Per Year
Employee Only	\$4,400
Employee + Family	\$8,750
Catch-Up Contribution (55+)	Additional \$1,000

### Triple Tax Savings

Your HSA offers triple tax savings,\* allowing you to save on taxes in three ways.

- **Pre-tax contributions:** Any money you contribute lowers your federal taxable income.
- **Tax-free growth:** The money in your account earns interest, and the investment earnings are tax-free, too.
- **Tax-free withdrawals:** HSA money you use to pay for eligible expenses is withdrawn tax-free.

### Who is Eligible for the HSA?

You can participate in the HSA only if you enroll in the HDHP. You are not eligible to contribute if:

- You are enrolled in Medicare.
- You are covered by another medical plan (such as your spouse's plan) that does not qualify as a high deductible health plan.
- You or your spouse participates in a Health Care Flexible Spending Account (FSA) at Muscatine CSD or at your spouse's employer.
- Note: Even if you do not contribute to the HSA, you cannot contribute to Muscatine CSD's Health Care FSA if you are enrolled in the HDHP.

# FUNDING ACCOUNTS

# FLEXIBLE SPENDING ACCOUNT

When you choose an FSA, it's important to know how it works. FSAs are use-it-or-lose-it plans. The funds you set aside must be used to pay for eligible expenses incurred during the plan year — between July 1 and June 30. You must submit your expense receipts by September 30th of the following year.

- Employees contribute money via payroll deductions.
- Employee designates how much to contribute for the year during enrollment up to IRS max.
- Money is typically deducted in equal installments each pay period.
- Employees cannot change their election during the year, unless there is a change in employment or family status.

	Dependent Care FSA	Limited Purpose Health Care FSA	Health Care FSA
<b>Available if you select these plans</b>	Any medical plan	High Deductible Health Plan	\$500 Traditional POS and \$750 Traditional PPO
<b>How much you may contribute</b>	\$7,500 per year or \$3,750 if married and filing separate tax returns	Up to \$3,400 for 2026 plan year	
<b>Expenses you may pay from your account</b>	Out of pocket expenses incurred during the current calendar year		
	<a href="#">Eligible dependent care expenses</a> including Day care After-school programs Elder care programs	<a href="#">Qualified dental or vision expenses</a>	<a href="#">Eligible expenses</a> including Medical copays Coinsurance Deductibles Eyeglasses Over-the-counter medications prescribed by your doctor
<b>Account balance available to reimburse expenses</b>	Entire contribution amount elected for the plan year		
<b>Time limits for using your account balance</b>	Must use 2026 account balance for expenses incurred through 6/30/2027; Claims must be filed by 9/30/2027		
<b>If you don't use all your account balance each year</b>	"Use it or lose it" applies (no roll over of unused funds allowed)	Any remaining funds over \$680 will be forfeited	
<b>How it saves you money</b>	Your contributions are tax-free, which reduces your taxable income and increases your take-home pay You pay for healthcare expenses with pre-tax dollars		

# MUSCATELINE EDUCATION MUSKIES

# INCOME PROTECTION



No one can predict the future, but you can plan for it. That's why Muscatine CSD provides eligible employees with Basic Life Insurance and Long-Term Disability Insurance. These coverages are administered by Lincoln Financial.

## LIFE INSURANCE

Life insurance pays a benefit if you or a covered family member dies.

### Basic Life Insurance

Muscatine CSD provides a \$50,000 Basic Life Insurance policy for all eligible employees at no cost. The benefit is paid to your beneficiaries in the event of your death.

### Supplemental Life Insurance

You can buy supplemental life insurance coverage for yourself and your family at your own expense. You pay for the cost of Optional Life Insurance on an after-tax basis through payroll deductions. Evidence of Insurability (EOI) is required if you add new coverage or increase current coverage. You must be enrolled in order to cover your spouse and/or children. The benefit is paid out to your beneficiaries in the even of your death, or to you in the event of their death.

Coverage Type	Coverage Amount
Employee	Increments of \$10,000 up to \$500,000 Guarantee Issue: \$180,000
Spouse	Increments of \$5,000 up to \$250,000 Guarantee Issue: \$50,000
Child(ren)	14 days – 6 months: \$250 6 months – age 26: \$10,000

\*When you or a covered dependent reaches age 65, Basic and Supplemental Life Insurance benefits are reduced. See plan document for full reduction schedules.

### Beneficiary Designation

You must name a beneficiary(ies) who will receive the benefit for your life and AD&D insurance. Beneficiaries can be changed at any time by calling Lincoln Financial at 888-787-2129.

## LONG-TERM DISABILITY

Muscatine CSD provides disability coverage through Lincoln Financial. Long-Term Disability insurance works to keep all or part of your paycheck coming if you cannot work because of an ongoing injury or illness.

### Eligibility

You may be eligible for LTD benefits if you remain totally disabled and unable to work for more than 90 days.

### Benefit

LTD benefits replace up to 70% of your base pay up to \$10,000.

Your LTD benefit will be reduced by other disability income, including:

- Social Security
- Workers' Compensation
- Any other applicable disability benefits

### When are you considered disabled?

- Approved by insurance carrier
- Seeing a doctor regularly for treatment
- Certified by a doctor that you are not able to perform the material duties of your regular occupation.

## SHORT-TERM DISABILITY

Employees can elect to purchase a Short-Term Disability policy through American Fidelity that would supplement their income prior to LTD. There are two benefits to choose from;

1. Benefits being on the 1st day after accident, 8th day after illness
2. Benefits being on the 1st day after accident, 15th day after illness



# OTHER BENEFITS

These benefits, administered by American Fidelity, offer an extra layer of protection for you and your family. The payment these benefits provide is in addition to any other insurance you may have and is yours to spend as you wish—to help cover bills or for everyday living expenses. These plans do not provide health insurance coverage and do not replace the medical plans



## CRITICAL ILLNESS

Critical illness insurance pays a lump-sum cash benefit directly to you if you are diagnosed with a covered illness or condition on or after your coverage effective date.



## ACCIDENT COVERAGE

Accident insurance pays a cash benefit directly to you when you are injured and require medical services due to a covered off-the-job accident that occurs on or after your coverage date. The benefit amount depends on the type of injury and care received.



## INDIVIDUAL TERM LIFE

Life insurance that has a death benefit with no cash accumulation feature. The policy is initially written for 10, 20, 30-year term period, but may be renewed at the insured's options for the same level renewal period depending upon the term chosen.



## HOSPITAL INDEMNITY

Hospital Indemnity insurance pays a cash benefit directly to you if you are hospitalized or or after your coverage effective date.



## INDIVIDUAL WHOLE LIFE

Life Insurance that provides protection for your entire life. Individual policy which means you own it and can take it with you when you leave employment or when you retire to age 121.



## CANCER

Provides a range of benefits that help cover the treatment of cancer, transportation, hospitalization and more.



# FEDLOGIC

FEDlogic is a benefit provided by Muscatine CSD that gives you free, confidential access to expert help with federal and state benefits. Their team of specialists helps you understand your options, avoid costly mistakes, and make confident decisions for you and your family.

- Medicare (approaching or already age 65)
- Social Security (retirement, disability, and survivor benefits)
- Medicaid
- COBRA and loss of health coverage
- Healthcare.gov
- Veterans' benefits
- Critical or catastrophic illness (ALS, dialysis, cancer)
- Disability or inability to work
- Premature birth or NICU support
- Survivor benefits after the loss of a spouse

## REASONS TO CALL A FEDLOGIC EXPERT:

- You're approaching or have reached age 65 and want help navigating Medicare
- You're 62+ and want to maximize your retirement benefits or plan for the future
- You or a family member have been diagnosed with a critical illness or disability
- You have a child born prematurely and is in the NICU
- You have lost a spouse and need help navigating survivor's benefits
- You are unable to work or have lost affordable health coverage

## HOW IT WORKS

1. **Make a phone consultation appointment.** Call **877-837-4196** or visit [fedlogicgroup.com](https://fedlogicgroup.com) and use **access code mcsd26** to schedule a phone consultation with an expert. Be sure to make the appointment at a time when family members are available to listen and ask questions as well. Calls typically last an hour and are unlimited, confidential, and free.
2. **Share your story, ask questions, and learn.** You don't have to wade through tons of complex and confusing information to figure out what applies to you. FedLogic takes the time to listen to your story and understand your needs, concerns, and goals. Then, they empower you with the unbiased information you need to maximize your benefits and make the best decision for your situation.
3. **Enroll in your benefits.** Once you feel confident you have all the information you need to make the best decision for you and your family, they will walk you through the application and approval process.
4. **Have Peace of Mind.** Without education and advocacy, many people don't tap into all the Social Security and Medicare benefits they've paid into during a lifetime of employment. You'll have the peace of mind knowing that you're getting all the benefits you deserve.

## CONNECT

877-837-4196 | [fedlogicgroup.com](https://fedlogicgroup.com) access code: mcsd26 | [Services@FedLogicGroup.com](mailto:Services@FedLogicGroup.com)

# CONTACTS

Plan	Carrier	Website	Phone
Medical	Wellmark Blue Cross Blue Shield	<a href="http://www.wellmark.com">www.wellmark.com</a>	(800) 524-9242
Pharmacy	VividClear Rx	<a href="http://www.vividclearrx.com">www.vividclearrx.com</a>	(877) 848-4379
Specialty Pharmacy	ScriptSourcing	<a href="http://www.scriptsourcing.com/med-finder">www.scriptsourcing.com/med-finder</a>	(410) 902-8811
Dental	Delta Dental of Iowa	<a href="http://www.deltadentalia.com">www.deltadentalia.com</a>	(800) 544-0718
Voluntary Vision	VSP Vision Care	<a href="http://www.vsp.com">www.vsp.com</a>	(800) 877-7195
Life & Disability Insurance	Lincoln Financial Group	<a href="http://www.lincolnfinancial.com">www.lincolnfinancial.com</a>	Life Number: (888) 787-2129 Disability Number: (800) 210-0268
Flexible Spending Voluntary Products	American Fidelity	<a href="mailto:Jordan.Leuschen@americanfidelity.com">Jordan.Leuschen@americanfidelity.com</a>	(785) 232-8100
<b>For Additional Assistance, Please Contact</b>			
	American Fidelity	Christopher Weaver <a href="mailto:christopher.weaver@americanfidelity.com">christopher.weaver@americanfidelity.com</a>	(785) 596-6428
	Holmes Murphy & Associates	Annie Salgado <a href="mailto:asalgado@holmesmurphy.com">asalgado@holmesmurphy.com</a> Allison Walters <a href="mailto:awalters@holmesmurphy.com">awalters@holmesmurphy.com</a>	(515) 223-6934 (319) 896-7640

# REQUIRED NOTICES

## HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

### 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 9.12% 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 9.12% of the

employee’s household income.<sup>1 2</sup>

**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.

#### 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.** 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](https://www.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 [healthcare.gov/medicaid-chip/getting-medicaid-chip](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 the Business Office. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1. Indexed annually; see [irs.gov/pub/irs-drop/tp-22-34.pdf](https://www.irs.gov/pub/irs-drop/tp-22-34.pdf) for 2023.
2. 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% 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.

## Special Enrollment Notice

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

### Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your

or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

### Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.

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

### Medicaid or CHIP

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

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

### For More Information or Assistance

To request special enrollment or obtain more information, please contact: Marsha Shingledecker at (563) 263-7223

## Your Information. Your Rights. Our Responsibilities.

*This notice describes:*

- HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
- YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION
- HOW TO FILE A COMPLAINT CONCERNING A VIOLATION OF THE PRIVACY OR SECURITY OF YOUR HEALTH INFORMATION, OR OF YOUR RIGHTS CONCERNING YOUR INFORMATION

YOU HAVE A RIGHT TO A COPY OF THIS NOTICE (IN PAPER OR ELECTRONIC FORM) AND TO DISCUSS IT WITH MUSCATINE COMMUNITY SCHOOL DISTRICT AT (563)263-7223 IF YOU HAVE ANY QUESTIONS.

**Please review it carefully.**

## Your Rights

You have the right to:

- Consent to most uses and disclosures of your health information
- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Discuss this notice with someone in our program
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

## Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

## Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

In these circumstances, we must protect your information and limit how we use and share it.

## Your Rights

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

### Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

### Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

### Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

### Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our health care operations after you have provided consent for all those purposes.
- We are not required to agree to your request, and we may say "no" if, for example, it could affect your care. If we agree to your request, we may still share this information in the event that you need emergency treatment.

### Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

### Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly upon such request.

### Discuss this notice with someone in our program

You can ask questions or obtain more information about this notice and our privacy practices by calling or emailing the contact person at the top of this notice.

### Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

## File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
- We will not retaliate against you for filing a complaint.

## Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

## Our Uses and Disclosures

### How do we typically use or share your health information?

We typically use or share your health information in the following ways.

#### Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

*Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

#### Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

*Example: We use health information about you to develop better services for you.*

*Example 2: A doctor treating you for a chronic condition asks a doctor at our program about your health condition and medications you are taking, for example, to avoid complications*

#### Pay for your health services

We can use and disclose your health information as we pay for your health services.

*Example: We share information about you with your dental plan to coordinate payment for your dental work.*

#### Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

*Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

#### How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. And in all cases, if we have substance use disorder patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, or legislative investigations or proceedings against you without (1) your consent or (2) a court order or subpoena. For more information see: <https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html>

#### Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence, only as required by applicable law
- Preventing or reducing a serious threat to anyone's health or safety

#### For your medical emergencies

We may use or share your health information with health care providers or emergency personnel when needed to provide you with emergency treatment or to respond to a serious and immediate threat to your health or safety, even when you are unable to consent. This is allowed under HIPAA's rules for treatment and emergency disclosures.

#### Do research

We can use or share your information for health research. Researchers cannot include any patient identifying information in their reports about the research.

#### Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

### **Respond to organ and tissue donation requests and work with a medical examiner or funeral director**

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

### **Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

### **Legal Proceedings and Lawful Process**

We may use or share your health information as permitted or required by law when responding to legal proceedings. This includes disclosures in response to a valid court order, warrant, subpoena, or other lawful process, consistent with HIPAA's rules for judicial and administrative proceedings (45 CFR §164.512(e)) and law enforcement requests (45 CFR §164.512(f)). When responding to legal requests, we disclose only the information required and follow all conditions and limitations imposed by HIPAA.

### **Communicate within our program and with contractors**

We may use and disclose your information within our health plan and with organizations that help us administer our program, including contractors and business associates who perform services for us. These disclosures occur only as permitted by HIPAA for health care operations.

### **Respond to audits and program oversight**

We may use and share your information for health oversight and health care operations. This includes sharing with government agencies that are authorized by law to conduct audits, inspections, and licensure activities, and with accrediting organizations to support accreditation, quality assessment and improvement, and program evaluation of our health plan. We share only the minimum necessary information as required by law.

### **Disclosure to Law Enforcement**

We may disclose information to law enforcement if we believe, in good faith, that it is evidence of a crime that occurred on our premises, or to report certain crimes during a medical emergency that did not occur on our premises. In these situations, we will disclose only what the law allows in these situations.

### **Our Responsibilities**

- We are required to obtain your consent for most uses and sharing of your information.
- We are required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

### **With Your Written Consent (42 CFR Part 2)**

If you provide written consent, we may use or disclose your Substance Use Disorder (SUD) information in the following ways:

- To the person or organization you name in your consent. Part 2 allows you to decide who may receive your SUD information through a written consent.
- To prevent multiple enrollments in withdrawal management or maintenance treatment programs. Part 2 permits disclosures for this purpose when authorized by your consent or as otherwise allowed by law.
- To report prescribed SUD treatment medications to a state Prescription Drug Monitoring Program when required by law. Part 2 allows this type of disclosure only when a state statute mandates such reporting.

### **Additional Protections for SUD Information (42 CFR Part 2)**

For records related to Substance Use Disorder (SUD) treatment, we will not disclose your information in any civil, criminal, administrative, or legislative proceeding without your written consent or a court order that meets the requirements of 42 CFR Part 2.

### **Respond to audits and program oversight**

For Substance Use Disorder (SUD) records protected by 42 CFR Part 2, organizations performing audits or evaluations must agree in writing not to redisclose your information and must destroy or return identifying information when the audit or evaluation is complete.

### **Redisclosure Rules for Substance Use Disorder (SUD) Information**

If you authorize us to disclose your SUD records to other health care providers or health plans for treatment, payment, or health care operations, those recipients may redisclose your information as permitted by the HIPAA Privacy Rule. However, your SUD information may *not* be used or disclosed in any civil, criminal, administrative, or legislative proceeding against you without your written consent or a court order that meets the requirements of 42 CFR Part 2.

We will include the required Part 2 notice prohibiting unauthorized redisclosure with every disclosure of SUD information.

### **Changes to the Terms of this Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

## **Important Notice from Muscatine Community School District About Your Prescription Drug Coverage and Medicare**

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Muscatine CSD 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. Muscatine CSD has determined that the prescription drug coverage offered by the VividClear Rx 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 15 to December 7.

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 coverage will not be affected. If you decide to join a Medicare drug plan and drop your current 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 Muscatine CSD and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

### **For More Information About Your Options Under Medicare Prescription Drug Coverage...**

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit [www.medicare.gov](http://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 informa-

tion about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://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: 2026-2027 Plan Year  
Name of Entity/Sender: Muscatine CSD  
Contact--Position/Office: Marsha Shingledecker, Benefits Administrator  
Address: 2900 Mulberry Ave, Muscatine, IA  
Phone Number: 563-263-7223

## Continuation Coverage Rights Under COBRA

### Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan.

**This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

**You may have other options available to you when you lose group health coverage.** For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

### What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This

is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

### When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

**For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Marsha Shingledecker at 563-263-7223**

## How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

### Disability Extension of 18-month Period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

### Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

### Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, [Children's Health Insurance Program \(CHIP\)](#), or other group health plan coverage options (such as a spouse's plan) through

what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

### Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

### If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov).

### Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

## Plan contact information

Marsha Shingledecker, 563-263-7223

1. <https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start>.

## Michelle's Law Enrollment Notice

*Note: Pursuant to Michelle's Law, you are being provided with the following notice because the Muscatine CSD group health plan provides dependent coverage beyond age 26 and bases eligibility for such dependent coverage on student status. Please review the following information with respect to your dependent child's rights under the plan in the event student status is lost.*

When a dependent child loses student status for purposes of Muscatine CSD group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the Muscatine CSD group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the Muscatine CSD group health plan, whichever is earlier.

In order to be eligible to continue coverage as a dependent during such leave of absence:

The Muscatine CSD group health plan must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary. To obtain additional information, please contact: Marsha Shingledecker at 563-263-7223

## Women's Health and Cancer Rights Act

### Enrollment 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 563-263-7223

## Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 563-263-7223 for more information.

## Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act (the Newborns' Act) provides protections for mothers and their newborn children relating to the length of their hospital stays following childbirth.

Under the Newborns' Act, group health plans may not restrict benefits for mothers or newborns for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. The 48-hour (or 96-hour) period starts at the time of delivery, unless a woman delivers outside of the hospital. In that case, the period begins at the time of the hospital admission.

The attending provider may decide, after consulting with the mother, to discharge the mother and/or her newborn child earlier. The attending provider cannot receive incentives or disincentives to discharge the mother or her child earlier than 48 hours (or 96 hours).

Even if a plan offers benefits for hospital stays in connection with childbirth, the Newborns' Act only applies to certain coverage. Specifically, it depends on whether coverage is "insured" by an insurance company or HMO or "self-insured" by an employment-based plan. (Check the Summary Plan Description, the document that outlines benefits and rights under the plan, or contact the plan administrator to find out if coverage in connection with childbirth is "insured" or "self-insured.")

The Newborns' Act provisions always apply to coverage that is self-insured. If the plan provides benefits for hospital stays in connection with childbirth and is insured, whether the plan is subject to the Newborns' Act depends on state law. Many states have enacted their own version of the Newborns' Act for insured coverage. If your state has a law regulating coverage for newborns and mothers that meets specific criteria and coverage is provided by an insurance company or HMO, state law will apply.

All group health plans that provide maternity or newborn infant coverage must include in their Summary Plan Descriptions a statement describing the Federal or state law requirements applicable to the plan (or any health insurance coverage offered under the plan) relating to hospital length of stay in connection

with childbirth for the mother or newborn child.

For more information, see the [Frequently Asked Questions \(FAQs\)](#) About the Newborns' and Mothers' Health Protection Act.

## 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 balance 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 the Business Office.

## 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](http://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](http://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](http://www.askebsa.dol.gov) or call **1-866-444-EBSA (3272).**

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2026. Contact your State for more information on eligibility –

STATE	WEBSITE/EMAIL	PHONE
<b>Alabama</b> Medicaid	<a href="http://myalhipp.com">myalhipp.com</a>	855-692-5447
<b>Alaska</b> Medicaid	Premium Payment Program: <a href="http://myalhipp.com">myalhipp.com</a> Medicaid Eligibility: <a href="http://health.alaska.gov/dpa">health.alaska.gov/dpa</a> Email: <a href="mailto:customerservice@myalhipp.com">customerservice@myalhipp.com</a>	866-251-4861
<b>Arkansas</b> Medicaid	<a href="http://myarhipp.com/">http://myarhipp.com/</a>	855-MyARHIPP (855-692-7447)
<b>California</b> Medicaid	<a href="http://dhcs.ca.gov/hipp">dhcs.ca.gov/hipp</a> Email: <a href="mailto:hipp@dhcs.ca.gov">hipp@dhcs.ca.gov</a>	916-445-8322 916-440-5676 (fax)
<b>Colorado</b> Medicaid and CHIP	Medicaid: <a href="http://healthfirstcolorado.com">healthfirstcolorado.com</a> CHIP: <a href="http://hcpf.colorado.gov/child-health-plan-plus">hcpf.colorado.gov/child-health-plan-plus</a> HIBI: <a href="http://mycohibi.com">mycohibi.com</a>	800-221-3943 Relay 711 800-359-1991 Relay 711 855-692-6442
<b>Florida</b> Medicaid	<a href="http://flmedicaidtplecovery.com/flmedicaidtplecovery.com/hipp/index.html">flmedicaidtplecovery.com/flmedicaidtplecovery.com/hipp/index.html</a>	877-357-3268
<b>Georgia</b> Medicaid	HIPP: <a href="http://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a> CHIPRA: <a href="http://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra">medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra</a>	678-564-1162, press 1 678-564-1162, press 2
<b>Indiana</b> Medicaid	HIPP: <a href="https://www.in.gov/fssa/dfr/">https://www.in.gov/fssa/dfr/</a> All other Medicaid: <a href="http://in.gov/medicaid">in.gov/medicaid</a>	800-403-0864 800-457-4584
<b>Iowa</b> Medicaid and CHIP (Hawki)	Medicaid: <a href="http://hhs.iowa.gov/programs/welcome-iowa-medicaid">hhs.iowa.gov/programs/welcome-iowa-medicaid</a> Hawki: <a href="http://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki">hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki</a> HIPP: <a href="http://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp">hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp</a>	800-338-8366 800-257-8563 888-346-9562
<b>Kansas</b> Medicaid	<a href="http://kancare.ks.gov">kancare.ks.gov</a>	800-792-4884 HIPP: 800-967-4660
<b>Kentucky</b> Medicaid and CHIP	KI-HIPP: <a href="http://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a> KI-HIPP Email: <a href="mailto:KIHIPPPROGRAM@ky.gov">KIHIPPPROGRAM@ky.gov</a> KCHIP: <a href="http://kynect.ky.gov">kynect.ky.gov</a> Medicaid: <a href="http://chfs.ky.gov/agencies/dms">chfs.ky.gov/agencies/dms</a>	KI-HIPP: 855-459-6328  KCHIP: 877-524-4718
<b>Louisiana</b> Medicaid	Medicaid: <a href="http://ldh.la.gov/healthy-louisiana">ldh.la.gov/healthy-louisiana</a> or email: <a href="mailto:healthy@la.gov">healthy@la.gov</a> LaHIPP: <a href="http://www.ldh.la.gov/lahipp">www.ldh.la.gov/lahipp</a> or email: <a href="mailto:La.HIPP@la.gov">La.HIPP@la.gov</a>	Medicaid: 888-342-6207 LaHIPP: 855-618-5488
<b>Maine</b> Medicaid	Enrollment: <a href="http://mymaineconnection.gov/benefits">mymaineconnection.gov/benefits</a> Private health insurance premium: <a href="http://maine.gov/dhhs/ofa/applications-forms">maine.gov/dhhs/ofa/applications-forms</a>	Enroll: 800-442-6003 Private HIP: 800-977-6740 TTY/Relay: 711
<b>Massachusetts</b> Medicaid and CHIP	<a href="http://mass.gov/masshealth/pa">mass.gov/masshealth/pa</a> Email: <a href="mailto:masspremassistance@accenture.com">masspremassistance@accenture.com</a>	800-862-4840 TTY/Relay: 711
<b>Minnesota</b> Medicaid	<a href="http://mn.gov/dhs/health-care-coverage">mn.gov/dhs/health-care-coverage</a>	800-657-3672
<b>Missouri</b> Medicaid	<a href="http://dss.mo.gov/mhd/participants/pages/hipp.htm">dss.mo.gov/mhd/participants/pages/hipp.htm</a>	573-751-2005
<b>Montana</b> Medicaid	HIPP: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a> HIIPP Email: <a href="mailto:HSHIIPPProgram@mt.gov">HSHIIPPProgram@mt.gov</a>	800-694-3084

<b>Nebraska</b> Medicaid	<a href="http://ACCESSNebraska.ne.gov">ACCESSNebraska.ne.gov</a>	855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
<b>Nevada</b> Medicaid	Medicaid: <a href="http://dhcftp.nv.gov">dhcftp.nv.gov</a>	800-992-0900
<b>New Hampshire</b> Medicaid	<a href="http://dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program">dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program</a> Email: <a href="mailto:DHHS.ThirdPartyLiabi@dhhs.nh.gov">DHHS.ThirdPartyLiabi@dhhs.nh.gov</a>	603-271-5218 or 800-852-3345, ext. 15218
<b>New Jersey</b> Medicaid and CHIP	Medicaid: <a href="http://state.nj.gov/humanservices/dmahs/clients/medicaid">state.nj.gov/humanservices/dmahs/clients/medicaid</a> CHIP: <a href="http://njfamilycare.org/index.html">njfamilycare.org/index.html</a>	Medicaid: 800-356-1561 CHIP Premium Assist: 609-631-2392 CHIP: 800-701-0710 TTY/Relay: 711
<b>New York</b> Medicaid	<a href="http://health.ny.gov/health_care/medicaid">health.ny.gov/health_care/medicaid</a>	800-541-2831
<b>North Carolina</b> Medicaid	<a href="http://medicaid.ncdhhs.gov">medicaid.ncdhhs.gov</a>	919-855-4100
<b>North Dakota</b> Medicaid	<a href="http://hhs.nd.gov/healthcare">hhs.nd.gov/healthcare</a>	844-854-4825
<b>Oklahoma</b> Medicaid and CHIP	<a href="http://insureoklahoma.org">insureoklahoma.org</a>	888-365-3742
<b>Oregon</b> Medicaid	<a href="http://healthcare.oregon.gov/Pages/index.aspx">healthcare.oregon.gov/Pages/index.aspx</a>	800-699-9075
<b>Pennsylvania</b> Medicaid and CHIP	Medicaid: <a href="http://pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html">pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html</a> CHIP: <a href="http://dhs.pa.gov/CHIP/Pages/CHIP.aspx">dhs.pa.gov/CHIP/Pages/CHIP.aspx</a>	Medicaid: 800-692-7462 CHIP: 800-986-KIDS (5437)
<b>Rhode Island</b> Medicaid and CHIP	<a href="http://eohhs.ri.gov">eohhs.ri.gov</a>	855-697-4347 or 401-462-0311 (Direct RIte Share Line)
<b>South Carolina</b> Medicaid	<a href="http://scdhhs.gov">scdhhs.gov</a>	888-549-0820
<b>South Dakota</b> Medicaid	<a href="http://dss.sd.gov">dss.sd.gov</a>	888-828-0059
<b>Texas</b> Medicaid	<a href="http://hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program">hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program</a>	800-440-0493
<b>Utah</b> Medicaid and CHIP	UPP: <a href="http://medicaid.utah.gov/upp/">medicaid.utah.gov/upp/</a> UPP Email: <a href="mailto:upp@utah.gov">upp@utah.gov</a> Adult Expansion: <a href="http://medicaid.utah.gov/expansion/">medicaid.utah.gov/expansion/</a> Utah Medicaid Buyout Program: <a href="http://medicaid.utah.gov/buyout-program/">medicaid.utah.gov/buyout-program/</a> CHIP: <a href="http://chip.utah.gov">chip.utah.gov</a>	UPP: 877-222-2542
<b>Vermont</b> Medicaid	<a href="http://dvha.vermont.gov/members/medicaid/hipp-program">dvha.vermont.gov/members/medicaid/hipp-program</a>	800-250-8427
<b>Virginia</b> Medicaid and CHIP	<a href="http://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select">coverva.dmas.virginia.gov/learn/premium-assistance/famis-select</a> <a href="http://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs">coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs</a>	Medicaid/CHIP: 800-432-5924
<b>Washington</b> Medicaid	<a href="http://hca.wa.gov">hca.wa.gov</a>	800-562-3022
<b>West Virginia</b> Medicaid and CHIP	<a href="http://dhr.wv.gov/bms/">dhr.wv.gov/bms/</a> <a href="http://mywvhipp.com/">mywvhipp.com/</a>	Medicaid: 304-558-1700 CHIP: 855-699-8447
<b>Wisconsin</b> Medicaid and CHIP	<a href="http://dhs.wisconsin.gov/badgercareplus/p-10095.htm">dhs.wisconsin.gov/badgercareplus/p-10095.htm</a>	800-362-3002
<b>Wyoming</b> Medicaid	<a href="http://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility">health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility</a>	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  
[dol.gov/agencies/ebsa](https://dol.gov/agencies/ebsa)  
\_866-444-EBSA (3272)

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
[cms.hhs.gov](https://cms.hhs.gov)  
\_877-267-2323, Menu Option 4, ext. 61565

## Patient Protection Notice

The Point of Service Plan with Wellmark 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. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the number on the back of your Wellmark ID card.

You do not need prior authorization from Wellmark Blue Cross Blue Shield 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.

## 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](mailto:ebsa.opr@dol.gov) and reference the OMB Control Number 1210-0137.



**MUSCATINE**  
COMMUNITY SCHOOL DISTRICT