If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 27 for more details.

2024–2025 BENEFITS ENROLLMENT GUIDE

The choice is yours.

BENEFITS FOR A HEALTHY LIFE

ADM COMMUNITY SCHOOLS

WELCOME to *your* 2024 Open Enrollment

We recognize how important benefits are to you. That’s why we’re committed to helping you and your family enjoy the best possible physical, financial, and emotional well-being. It’s also why we provide you with a comprehensive, benefits package, with the flexibility to make the choices that best meet your needs.

Use this guide to better understand your 2024-2025 benefits options. Then, be sure to make your choices by the enrollment deadlines to receive coverage for the coming year.

Inside this guide

Summary of Benefits and Coverage

The Health section of this guide provides an overview of your medical plan options. You can find detailed information about each plan, including a breakdown of costs, in each plan's Summary of Benefits and Coverage (SBC). The SBCs summarize important information about your health coverage options in a standard format to help you compare costs and features across plans. The SBCs are available on **WWW.BENEFITSOLVER.COM.** A paper copy is also available by calling 515 993 4283**.**

Important reminders

- **If you want to keep your current benefits in 2024-2025**, you don't have to do anything during the enrollment period. We encourage you to log into your **www.Benefitsolver.com** account to review your current coverage as this is your only opportunity to make election changes without a qualified life event.
- If you're currently participating in FSA accounts, your contribution amounts won't carry forward — you are required to re-enroll each year.
- **Open Enrollment: Enroll before the enrollment deadline.** If you miss the deadline and don't enroll or make changes to your benefits, your current medical, dental and vision benefits and any District –paid coverage, Life/AD&D and LTD, will continue but you won't be able to participate in any FSA's. You will have to wait until the next Open Enrollment, unless you experience a qualified life event, to enroll or change benefits.
- **New employees: Enroll within 30 days from your date of hire.** If you don't enroll within this time, you won't have benefits coverage, except for plans and programs that are fully for paid by the District, such as Life, AD&D and LTD.

Who can enroll?

- Full-time employees (30+ hrs./wk.) – Eligible upon hire; must choose benefits within 30 days of hire date.
- Eligible dependents – Includes your legal spouse/domestic partner and children to age 26, plus dependent disabled children of any age who meet plan criteria.

Effective date of coverage

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

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

Providing great benefit choices to you and your family is just one of the many ways we support the physical, financial, and emotional well-being of the people who make our District successful — you.

HEALTH

Quality health coverage is one of the most valuable benefits you enjoy as a District employee. Our benefits program offers plans to help keep you and your family healthy and to provide important protection in the event of illness or injury.

Medical

You have a choice of medical plans with a range of coverage levels and costs. This gives you the flexibility to choose what's best for your needs and budget.

2024-2025 medical plan options

- **Copay 1250,** Moderately priced option that utilizes the broadest Wellmark provider network within Iowa and throughout the USA.
- **HMO**, lowest out-of-pocket costs if all your services are within Wellmark's HMO network. Out-of-network coverage for emergency services only.
- **POS 750,** lowest premium costs and coverage is based on who you see in the POS network. Unlike the HMO, you may have out-of-network coverage depending on the providers participation in BCBS networks. You receive best level of coverage if you stay within the Wellmark POS network.

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

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

Key features

All your medical plan options offer:

- Comprehensive, affordable coverage for a wide range of health care services.
- Free in-network preventive care, with services such as annual physicals, recommended immunizations,
  well- woman and well-child exams, flu shots, vision exam and routine cancer screenings covered at 100%.
- Prescription drug coverage included with each medical plan.
- Financial protection through out-of-pocket maximums that limit the amount you'll pay each year.
- Choice of coverage levels: Single, 2 Person and Family.

Which plan is right for you?

Consider which features are most important to you. Do you want to:	HMO	POS 750	Copay 1250
Pay the lowest premium cost, which may make it the least expensive option if you expect to have low health care usage?		X	
Lower your out-of-pocket costs by choosing the HMO narrower network with 100% of hospitals and 96% of physicians in Iowa?	X		
Pay a higher premium cost to have the broadest Provider network when you need care?			X

Monthly Medical Premiums
Please refer to the Rate page at the back of this Guide and log into your Benefitsolver account for your monthly cost. Note: The rates in Benefitsolver are based on 12 month premium.

Medical plan costs

You and the District share the cost of your medical benefits — the District pays a portion of the total cost and you pay the remainder through payroll deductions. Your specific cost is determined by the plan you choose and the coverage level you select.

Compare medical plans

The chart below compares key coverage features and costs of Adel-DeSoto-Minburn CSD's 2024 – 2025 medical plan options.

Plan / Wellmark Provider Network	HMO / HMO		POS 750 / POS		Copay 1250 / PPO	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Deductible - Calendar year						
Per person / per family	NA	Not Covered	$750 / $1,500		$1,250 / $2,500	
Coinsurance %	10%	Not Covered	10%	20%	20%	30%
Out-of-pocket maximum - Calendar year						
Per person / per family	$750 / $1,500	Not Covered	$1,500 / $3,000		$2,500 / $5,000	
Medical coverage						
PPO Office PCP Visit / **HMO/POS Designated PCP Office Visit^**	**$5**	Not Covered	**$10**	Deductible, than coinsurance	$10	Deductible, than coinsurance
HMO/POS PCP Office Visit^^	$10		$15		NA	
PPO Non-PCP Office Visit / HMO/POS Non-PCP Office Visit^^^	$10		$30		$10	
Telemedicine	$10		$15			
Behavioral Health Office Visit*	$10		$15			
Preventive care - Adult and Well-Child	Covered in Full		Covered in Full		Covered in Full	
Outpatient serivces	Deductible, than coinsurance		Deductible, than coinsurance		Deductible, than coinsurance	
Inpatient hospital						
Emergency room	$50 copay					
Labs and X-rays	Deductible, than coinsurance	Not Covered				
Designate a Primary Care Provider (PCP)	Required		Required		NA	
Retail prescription drugs (30-day supply)						
Prescription Deductible (Per person / per family)	NA		NA		NA	
Tier 1	$5		$8		$10	
Tier 2	$10		$35		$20	
Tier 3	$10		$50		$30	
Specialty - Generic and Biosimilar / Preferred / Non-Preferred	$50 / $85 / $100	Not Covered	$50 / $85 / $100	Not Covered	$50 / $85 / $100	Not Covered
Prescription Out-Of-Pocket Maximum (Per person / per family)	$1,500 / $3,000		$1,500 / $3,000		$500 / $1,000	
Mail-order prescription drugs (90-day supply) Maintenance Drugs						
Tier 1	$10	Not Covered	$16	Not Covered	$20	Not Covered
Tier 2	$20		$70		$40	
Tier 3	$20		$100		$60	

Deductible is waived for non-HDHP plans for office and telemedicine visits with a network provider.

HMO and POS Plans:

^Office visit copay for your Designated Network PCP.

^^Office visit copay for any other Network PCP office visit.

^^^Office visit copay for Network non-PCP.

Primary Care Practitioner (PCP) is defined as General Practice, Family Practice, Internal Medicine, Obstetrics/gynecology, Pediatricians, Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants.

Chiropractors, Speech Pathologists, Physical Therapists, Occupational Therapists and Mental Health/Chemical Dependency office copay amount is the same as the office PCP amount.

All other providers are Non-Primary Care Practitioners (Non-PCP).

This is a general description of coverage. It is not a statement of your contract. Actual coverage is subject to terms and conditions specified in the Benefits Certificate itself and enrollment regulations in force when the benefits become effective. Certain exclusions and limitations apply.

Money-saving tips

To stretch your health care dollars, remember to:

- **See in-network providers** – They've agreed to the plan's negotiated rates. Visit your plan website to search for in-network providers near you.
- **Use the mail-order pharmacy** – It will save you time and money when refilling long-term prescriptions.

Flexible spending accounts (FSAs)

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

Adel-DeSoto-Minburn CSD offers you the following FSAs:

Health Care FSA

- Pay for eligible health care expenses, such as plan deductibles, copayments, and coinsurance, but not insurance premiums.
- Contribute up to $3,200.*

Dependent Care FSA

- Pay for eligible dependent care expenses, such as daycare so you can work, look for work, or attend school full time.
- Contribute up to $5,000 per calendar year,* or $2,500* per spouse if you are married and filing separate tax returns.

** These are 2024 limits. The 2025 limits weren't available when this guide was printed.*

Estimate carefully

Keep in mind, FSAs are "use-it-or-lose-it" accounts. You generally must use the money in an FSA within the plan year or forfeit any remaining balance. However, Adel-DeSoto-Minburn CSD offers the following:

- An option to carry over up to $640 from the 2024 plan year to the 2025 plan year.
- FSA plan year is July 1st to June 30th.

Health Care FSA: Let's summarize

	Health Care FSA
Available if you enroll in a…	PPO plan
Eligible for District contributions	No
Change your contribution amount anytime	No
Access your entire annual contribution amount from the beginning of the plan year	Yes
Access only funds that have been deposited	No
"Use it or lose it" at year-end	Yes, except for rollover amount ($640)
Money is always yours to keep	No

Managing your FSA(s)

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

What's an eligible expense?

- Health Care and Limited-Purpose FSAs – Plan deductibles, copays, coinsurance, and other health care expenses. To learn more, see IRS Publication 502 at **www.irs.gov.**
- Dependent Care FSA – Child day care, babysitters, home care for dependent elders, and related expenses. To learn more, see IRS Publication 503 at **www.irs.gov.**

Dental plan

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

Benefit Period = Calendar Year	Delta Dental PPO Voluntary Preventive Plan			Delta Dental PPO Voluntary Catastrophic Plan			Delta Dental PPO Voluntary Comprehensive Plan		
Schedule of Benefits	**PPO Dentist**	**Premier Dentist**	**Out-of-Network Dentist**	**PPO Dentist**	**Premier Dentist**	**Out-of-Network Dentist**	**PPO Dentist**	**Premier Dentist**	**Out-of-Network Dentist**
Annual Deductible	$50	$50	$75	$0	$100	$150	$50	$150	$225
Covered Services - Coinsurance Amounts are what the Insured Pays									
Check Ups and Teeth Cleaning (Diagnostic & Preventive) Teeth Cleaning, Oral Evaluations, Fluoride Applications, Sealant Applications, Space Maintainers, X-rays	Deductible, then 20% Coins	Deductible, then 30% Coins	Deductible, then 50% Coins	Not Covered			Deductible, then 20% Coins	Deductible, then 30% Coins	Deductible, then 50% Coins
Cavity Repair (Routine and Restorative) Emergency Treatment Restoration of Decayed or Fractured Teeth Limited Occlusal Adjustment *Excluded:* General Anesthesia/Sedation, Routine Oral Surgery, Tooth Extraction	Deductible, then 50% Coins	Deductible, then 50% Coins	Deductible, then 70% Coins				Deductible, then 50% Coins	Deductible, then 50% Coins	Deductible, then 70% Coins
Root Canals (Endodontics) Root Canal Therapy, Retrograde filings, Apicoectomy, Pulpotomy, Direct pulp caps	Not Covered			Deductible waived, 40% Coins	Deductible, then 50% Coins	Deductible, then 70% Coins	Deductible, then 40% Coins	Deductible, then 50% Coins	Deductible, then 70% Coins
Gum and Bone Diseases (Periodontics) Conservative Procedures (Non-Surgical) Complex Procedures (Surgical), Maintenance Therapy									
High Cost Restorations (Cast Restorations) Crowns, posterior composites, Onlays, Inlays, Posts and Cores									
Dentures and Bridges (Proshetics) Dentures, Partials, Bridges, Repairs and Adjustments									
Orthodontic	Not Covered			Not Covered			Not Covered		
Annual Maximum	No coverage limit for routine and preventive care			**$1,250**			**$1,250**		

Employee must remain on one plan for 12 months before switching to another plan. 24-month waiting period to re-enroll if coverage is dropped.

Monthly Dental Premiums

Please refer to the Rate page at the back of this Guide and log into your Benefitsolver account for your monthly cost.

Note: The rates in Benefitsolver are based on 12 month premium.

Money-saving tip

Remember, you can use your FSA for qualified out-of-pocket dental and vision expenses.

Vision plan

Having vision coverage allows you to save money on eligible eye care expenses, such as periodic eye exams, eyeglasses, contact lenses, and more for yourself and your covered dependents.

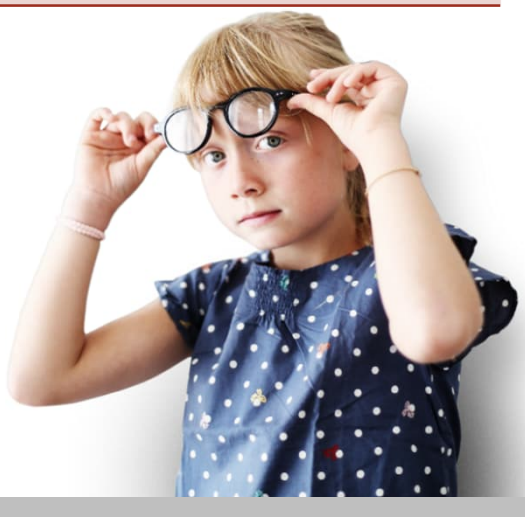
AVESIS VISION	Plan A Materials Only	Plan B Eye exam + Materials
Eye Exam	NA	$10
Materials (copay applies to frame or spectacle lens, if applicable)	$15	$15
Frame Allowance Up to 20% discount above frame allowance.*	up to $50 wholesale allowance, up to $150 retail value	up to $50 wholesale allowance, up to $150 retail value
Lenses - Single, Bifocal, Trifocal, Lenticular	Covered in full after materials copay	Covered in full after materials copay
Standard Progressives **Other lens options**	up to $50, plus 20% off retail discounted up to 20% off retail	See chart
Contact Lenses (in lieu of frame and spectacle lenses)		
Elective	$130 allowance	$130 allowance
Medically Necessary	Covered in full	Covered in full
Refractive Laser Surgery	Onetime/Lifetime $150 allowance. Provider discount up to 25%.	Onetime/Lifetime $150 allowance. Provider discount up to 25%.
Frequency		
Eye Examination	NA	Once every 12 months
Lenses or contact lenses	Once every 12 months	Once every 12 months
Frame	Once every 24 months	Once every 24 months

Lens Option Package	Plan B Only
Polycarbonate (Single Vision/Multi-Focal)	$40/$44 (Covered in full up to age 19)
Standard Scratch-Resistant Coating	$17
Ultra-Violet Screening	$15
Solid or Gradient Tint	$17
Standard Anti-Reflective Coating	$45
Level I Progressives	$75
Level 2 Progressives	$110
All Other Progressives	$50 allowance + 20% discount
Transitions® (Single Vision / Multi-Focal)	$70/$80
Polarized	$75
PGX/PBX	$40
Other Lens Options	Up to 20% Discount

Monthly Vision Premiums

Please refer to the Rate page at the back of this Guide and log into your Benefitsolver account for your monthly cost.

Note: The rates in Benefitsolver are based on 12 month premium.



Wellness

Our wellness resources are designed to help you maintain or move toward a healthy lifestyle through preventive care and other assistance when you need it. You also have access to tools and resources you can use to learn more about your personal health and monitor your progress toward your health goals. Visit **www.Wellmark.com, www.deltadentalia.com, www.avesis.com and www.healthadvocate.com** for more information.

Employee assistance program

The Adel-DeSoto-Minburn CSD Employee Assistance Program (EAP) is available throughout the year to assist with your everyday needs, at no cost to you. It's all part of our commitment to supporting your total well-being. Get help with work-life issues; referrals for clinical, legal, and financial services; and more. To begin taking advantage of this valuable benefit, visit **www.guideanceresources.com** or call 800 964 3577.

Take advantage of preventive care benefits

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

1. **Have a routine physical exam each year.** You'll build a relationship with your doctor and can reduce your risk for many serious conditions.
2. **Get regular dental cleanings.** Numerous studies show a link between regular dental cleanings and disease prevention — including lower risks of heart disease, diabetes, and even a stroke.
3. **See your eye doctor at least once every two years.** If you have certain health risks, such as diabetes or high blood pressure, your doctor may recommend more frequent eye exams.

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

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

Health Advocacy Resources

Questions on your coverage, claims, diagnosis, treatments?

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

Visit **www.healthadvocate.com** for more information.

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

Get care from your couch

When you don't feel well, or your child is sick, the last thing you want to do is leave the comfort of your home to sit in a crowded waiting room full of other sick people. A virtual consultation lets you talk with a doctor from the comfort of your home or office without an appointment. Virtual visits cost about the same as in-person office visits. Consider a virtual visit when your doctor isn't available, you become ill while traveling, or you're considering visiting a hospital emergency room for a non-emergency health condition. To learn more and register for care, go to **www.Wellmark.com** or direct to the vendor website at **www.doctorondemand.com.**

Did you know…You can use Dr on demand for medical treatment as well as behavior health services.

Virtual V**isits can be used for:** Depression, Workplace stress, Relationship issues, Trauma and loss, Social or general anxiety and Addictions

Comfortable, Connected, Confidential

- As a part of your health benefits, you can connect with a licensed therapist – or psychiatrist for more complex issues – to listen and help you find solutions.

Getting Started is easy. Download and register today.

- Download the Doctor On Demand App or visit **www.DoctorOnDemand.com**
- Have your Wellmark Blue Cross and Blue Shield member ID card ready
- Create an account or sign in

FINANCIAL

Adel-DeSoto-Minburn CSD offers programs to help ensure financial security for you and your family. We also provide access to voluntary benefits designed to help you save money on valuable supplemental insurance coverage.

Basic life and AD&D insurance

You automatically receive basic life and accidental death and dismemberment (AD&D) insurance, if you meet the eligibility requirements, so that you can protect those you love from the unexpected.

There is no cost to you for this coverage. You can also choose supplemental coverage.

District provided*

- Flat $40,000
- Employee basic AD&D** equal to the employee basic life benefit.
- Eligibility: Full-time active employees.
  - Full-time employment: at least 30 hours weekly.
- See Certificate for more details.

** Federal tax law requires Adel-DeSoto-Minburn CSD to report the cost of employer-paid life insurance exceeding $50,000 as imputed income.*

*** AD&D benefits are paid in addition to any life insurance if you die in an accident or become seriously injured or physically disabled.*

Have you named a beneficiary?

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

Log into your **www.Benefitsolver.com** account to add or change a beneficiary.

Do you have a will?

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

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

Disability insurance

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

Summary of disability benefits

	Basic Long-Term Disability
Who pays	The District
Eligibility	Full-time active employees. Full-time Employment: at least 30 hours weekly
Benefit provided	Up to 60% of your base monthly salary
Maximum benefit payable	$5,000 per month
Maximum benefit duration	Own occupation – 2 years; After 2 years, any occupation. Up to Social Security Normal Retirement Age
Elimination period	120 days

Employee assistance program

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

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

1st time user, click Register. Organization WEB Id Field enter: HLF902; Company name enter: ABILI. Then create userid/password.

ENROLL

Carefully consider your benefit options and your anticipated needs. Then follow the instructions to enroll yourself and any eligible dependents in health and insurance benefits for 2024-2025.

How to enroll

Online

Log in to **www.Benefitsolver.com**
Enroll from any computer or smart phone with internet access, 24 hours a day, seven days a week. Follow the prompts to set up your account and select a secure password. You can reset your password through the website.

Yes, there's an App for that.

You can download the **myChoice app** on IOS and Android to access your BenefitSolver account on the go.

Reminders

Your current elections for **medical, dental and vision** will continue for the 2024-2025 plan year unless you make an election change during the open enrollment period.

FSA elections do not carry over. You must make a new election if you want to participate in the District FSA medical and/or dependent care savings account for the 2024-2025 plan year.

Contact the Business Office for information on how to make an election for the Flexible Spending Account (FSA).

Changes during the year

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

Effective date of coverage

For new employees, the effective date of coverage is first of the month following date of hire (e.g. start August 1st, benefits start September 1st).

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

Annual Enrollment will take place

May 2nd through May 16th at 11:59pm.

Contacts

Benefit Plan	Provider	Phone Number	Website
Medical	Wellmark	800 524 9242	www.Wellmark.com/member
Prescription	Wellmark / CVS Caremark	800 524 9242	www.Wellmark.com/prescriptions
Dental	Delta Dental of Iowa	800 544 0718	www.deltadentalia.com
Vision	Avesis	855 214 6777	www.avesis.com
Telemedicine services	Doctor on Demand	800 997 6196	www.doctorondemand.com
Personal Health Advocate	Health Advocate	866 695 8622	www.healthadvocate.com/members
Life / AD&D and Disability Insurance	Hartford	Business Office	www.thehartford.com/learn/egit
Flexible Spending Accounts (FSA's)	BASE	888 227-3105	www.baseonline.com/private/login
Employee assistance program (EAP)	ComPsych	800 964 3577	www.guidanceresources.com

Premium Contribution Rates

The information shown here illustrates the current premiums for Adel-DeSoto-Minburn CSD's benefit plans. Please review your options carefully and choose coverage that fits your budget and your family's lifestyle.

Premiums shown here are monthly premiums set by the carrier. Log into your www.Benefitsolver.com account to review your monthly costs for benefits.

Medical premiums

	HMO	POS 750	COPAY 1250
Employee Only	$651.32	$607.47	$647.12
2 Person	$1,259.81	$1,172.60	$1,251.46
Employee + Family	$1,896.24	$1,763.67	$1,883.54

Note: The rates shown here and in Benefitsolver are based on 12 month premium.

Dental premiums

	Preventive	Catastrophic	Comprehensive
Employee Only	$11.50	$13.78	$24.92
2 Person	$22.96	$26.42	$49.36
Employee + Family	$43.62	$28.70	$72.30

Vision premiums

	Materials Only	Materials + Exam
Employee Only	$7.76	$10.53
Employee + Spouse	$14.69	$20.16
Employee + Children	$16.00	$21.96
Employee + Family	$20.59	$28.27

Learn more

Visit www.Benefitsolver.com for more information about your Adel-DeSoto-Minburn CSD 2024-2025 benefit options and to review your monthly costs.

Notes

ENROLLING IS EASY

LOG IN

Visit **www.Benefitsolver.com** from any computer or smart device and **Login** with your **User Name** and **Password**.
New users must **Register** and answer security questions. Our case-sensitive company key is **etrust**.

GET STARTED

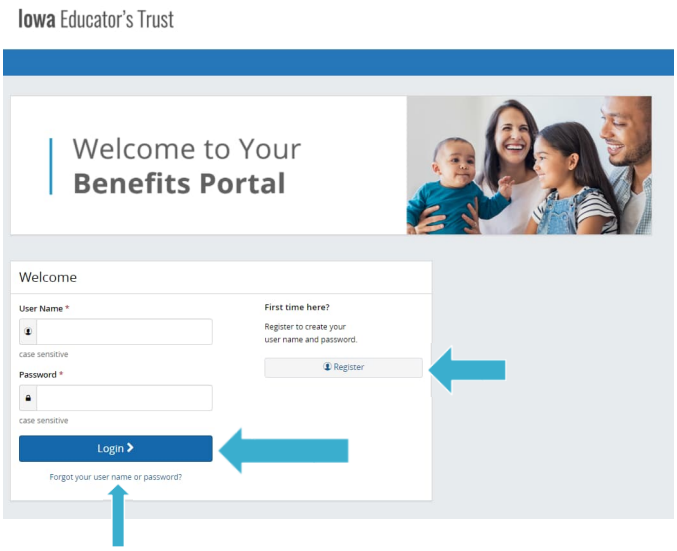
Click **Start Here** and follow the instructions to make your benefit choices by the deadline on the calendar. If you miss the deadline you will have to wait until the next annual enrollment period to enroll or make changes.

FIND INFORMATION

View plan details, carrier specifics and resources in the **Reference Center**.

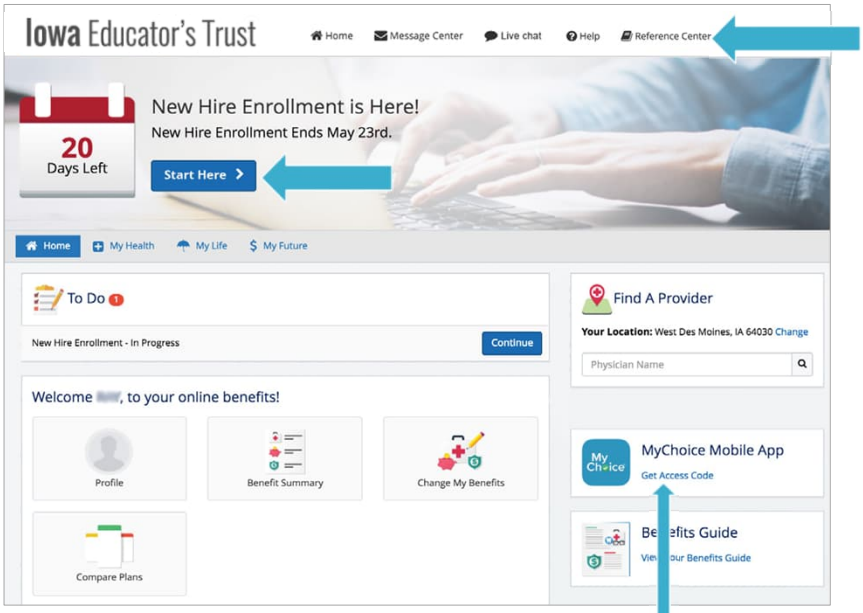
MAKE YOUR ELECTIONS

Using **Back** and **Next** to navigate, review your options as you move through the enrollment process.
Select plan(s) and who you would like to cover.



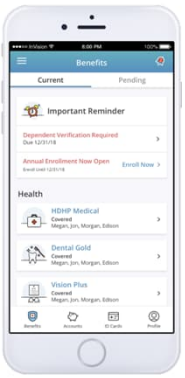
Need to reset your user name or password?

1. Click **Forgot your user name or password?**
2. Enter your Social Security number, birth date and our company key, **etrust**.
3. Answer your security phrase.
4. Enter and confirm your new password, then click **Continue** and **Login** with your new credentials.



Download the MyChoice℠ Mobile App

1. Visit your device's app store and download the **MyChoice by Businessolver®** Mobile App.
2. Visit **www.Benefitsolver.com** to **Get Access Code**.
3. Activate the app with your access code. (If you don't use the code within 20 minutes, you'll need to generate a new one.)
4. Follow the instructions within the Mobile App to have easy access to your benefits on the go.



Download on the App Store

GET IT ON Google Play

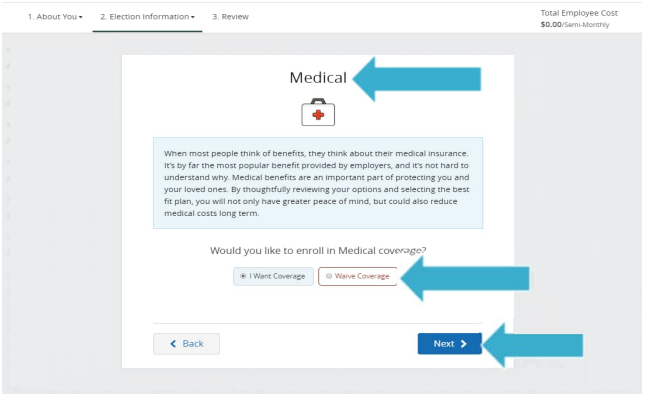
Iowa Educator's Trust

www.Benefitsolver.com
Company Key: etrust

REVIEW AND CONFIRM

Make sure your personal information, elections, dependents and beneficiaries are accurate and **Approve** your enrollment.

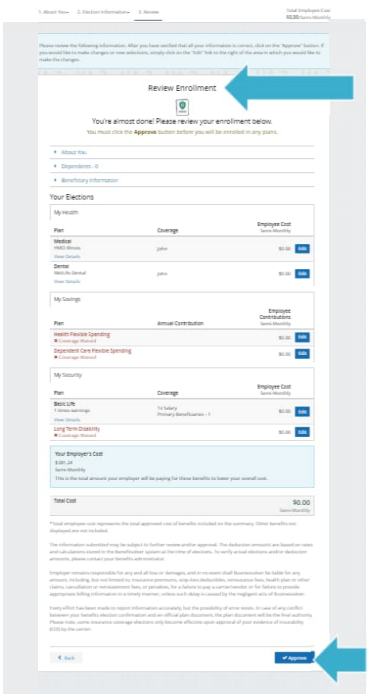
To finalize your enrollment, click **I Agree**.

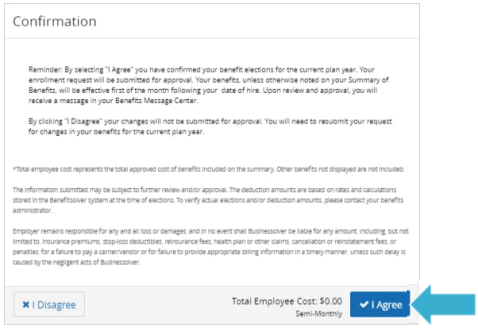


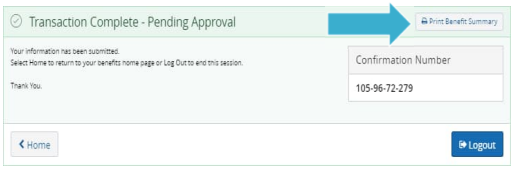
FINALIZE

When your enrollment is complete, you will receive a confirmation number and you can **Print Benefit Summary**.

Your **To Do** list will notify you if you have any additional actions needed to complete your enrollment.

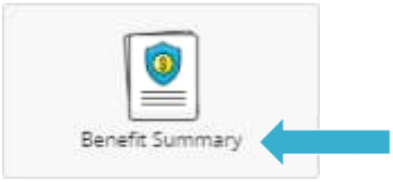


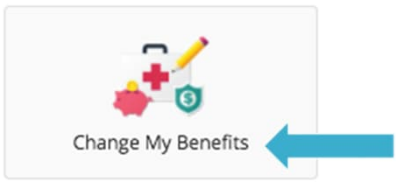


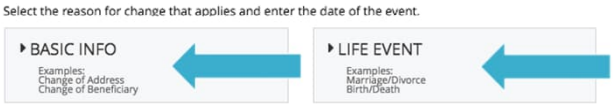


REVIEW YOUR BENEFITS

You have year-round access to a benefits summary that shows your personal selections. Click **Benefit Summary** on the homepage to review your current benefits at any time.







Change your benefits

Once approved, your benefit elections will remain in effect until the end of the plan year, unless you have a qualifying life event such as marriage, divorce or having a baby. Find detailed information in the **Reference Center**.

1. Click on **Change My Benefits**.
2. Select **Life Event** and the event type.
3. Review your options and follow the election steps outlined above to complete your changes.

****IMPORTANT:** You must make changes within **30 days** of the event and provide required documentation.

Change your beneficiary(ies)

1. Click on **Change My Benefits**
2. Select **Basic Info** and **Change of Beneficiary**.
3. Follow the prompts to complete your change.

Beneficiary changes can be made at any time of the year.

Iowa Educator's Trust

www.Benefitsolver.com
Company Key: etrust

Enroll in your 2024-2025 benefits on an App

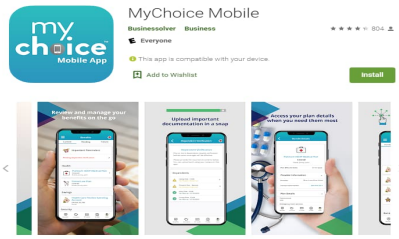
Iowa Educator's Trust

Open Enrollment – 2024

LOGIN + DOWNLOAD

To complete your enrollment on a mobile device, download the FREE **MyChoice Mobile App** for iOS or Android.

Log in using your Benefitsolver username and password. You may have to answer security questions and provide multi-factor authentication.

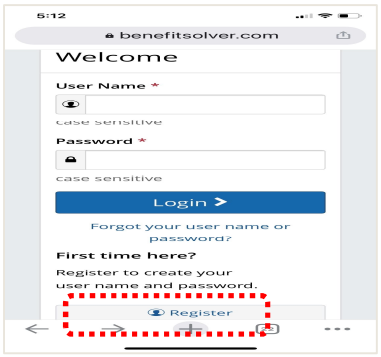


Download the App

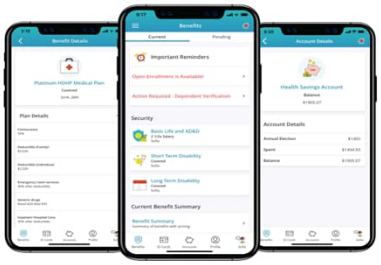
❖ **Don't have a user name and password?** Start at **www.benefitsolver.com** in your device's internet browser

First time users: Click **Register** .

- Enter your name, birth date, SSN and zip code.
- Once verified you can set your user name and password.
- You will be asked to set up security questions.
- The case-sensitive company key is **etrust** and should pre-populate.
- Log in using your new user name and password.

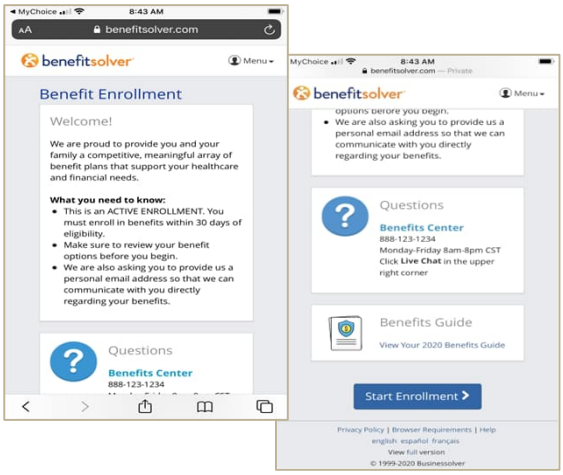


❖ **You may continue your mobile experience here in the browser or return to the MyChoice Mobile App.** In the app, use your Benefitsolver username and password to sign in.



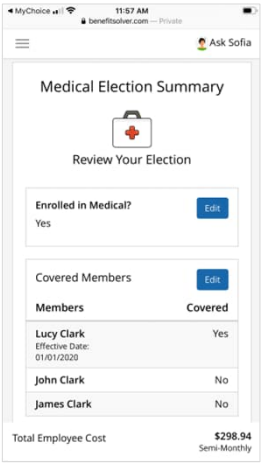
START YOUR ENROLLMENT

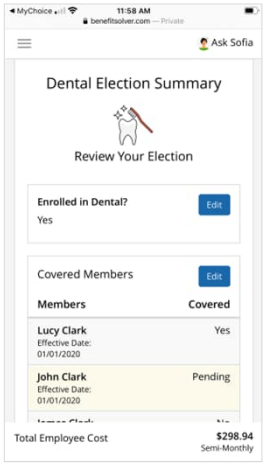
The **Important Reminders** will alert you that open enrollment is available. Tap that to begin.
Click the **Start Enrollment** button to review your personal information and add or edit any dependents you wish to cover.
You will need to provide each dependent's legal name, Social Security Number, and birth date to add them to your coverage.*
*You may be required to provide documentation to prove your relationship to each dependent.



EXPLORE YOUR OPTIONS

Explore the app to learn about your benefits. You'll find lots of helpful information in the **Reference Center**.

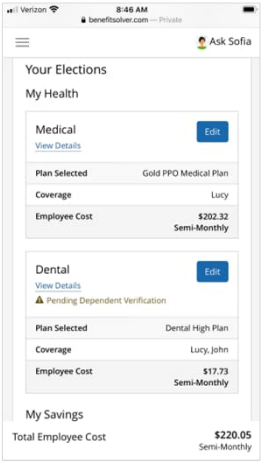


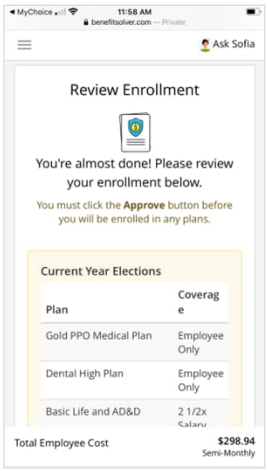


ENROLL IN COVERAGE

Use the **Next** and **Back** buttons to review and elect options available to you. Choose or decline coverage for each option and select which family members you want to cover.

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

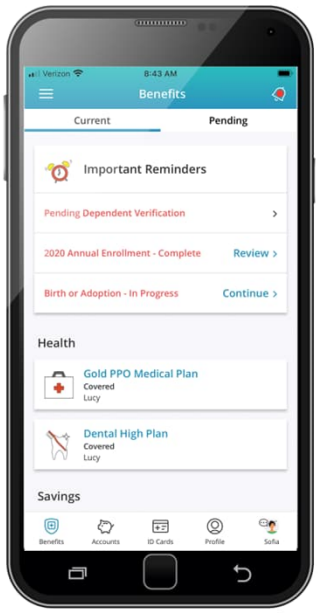


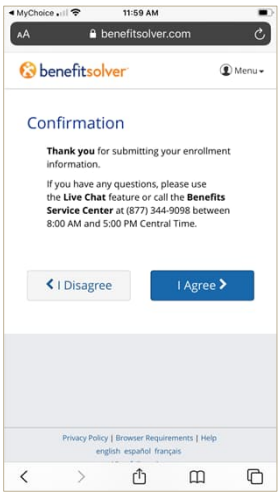


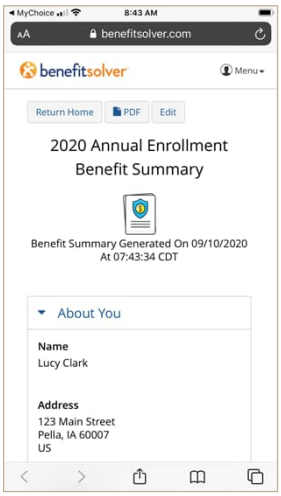
REVIEW AND FINALIZE YOUR ELECTIONS

Make sure your personal information, elections, dependents, and beneficiaries are accurate, then approve your elections.

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







AFTER YOU ENROLL

Return to the **Home** page to check for any additional tasks needed to complete your enrollment, view or download your **Benefit Summary.**

Visit the app anytime you want to learn more about your benefits or make a change to your coverage (if you experience a qualifying life event).

Annual Notices

The following pages are intended to be shared by employees with their spouse and dependents.

Important Notice to Employees from Adel-Desoto-Minburn CSD
About Creditable Prescription Drug Coverage and Medicare

The purpose of this notice is to advise you that the prescription drug coverage listed below under the Adel-Desoto-Minburn CSD medical plan are expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2024. This is known as "creditable coverage."

Why this is important. If you or your covered dependent(s) are enrolled in any prescription drug coverage during 2024 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty – as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

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

Please read the notice below carefully. It has information about prescription drug coverage with Adel-Desoto-Minburn CSD and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

Notice of Creditable Coverage

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

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

If you are covered by one of the Adel-Desoto-Minburn CSD prescription drug plans listed below, you'll be interested to know that the prescription drug coverage under the plans is, on average, at least as good as standard Medicare prescription drug coverage for 2024. This is called creditable coverage. Coverage under one of these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

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

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

You may receive this notice at other times in the future – such as before the next period you can enroll in Medicare prescription drug coverage, if this Adel-Desoto-Minburn CSD coverage changes, or upon your request.

For more information about your options under Medicare prescription drug coverage

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

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

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

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

Notice of Special Enrollment Rights for Medical Plan Coverage

As you know, if you have declined enrollment in Adel-Desoto-Minburn CSD's medical plan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under these plans without waiting for the next open enrollment period, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Adel-Desoto-Minburn CSD will also allow a special enrollment opportunity if you or your eligible dependents either:

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

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

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

Women's Health and Cancer Rights Act Notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call your plan administrator at *515-993-4283*

Newborns' and Mothers' Health Protection Act Notice

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

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

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

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

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

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, please notify ***Human Resources*** as soon as the need for the leave is recognized to Adel-Desoto-Minburn CSD. In addition, contact ***Human Resources*** should be notified to see if any state laws requiring extended coverage may apply to his or her benefits.

Provider-Choice Rights Notice - For HMO Plans

1. The Wellmark, Inc. generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the provider by using the 515-993-4283 on the back of your Wellmark Member ID Card

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

3. You do not need prior authorization from Wellmark, Inc. or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the provider by using the 515-993-4283 on the back of your Wellmark Member ID Card

No Surprises Act notice

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

You are protected from balance billing for:
Emergency services

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

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

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

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

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

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

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

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

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

HIPAA Privacy notice reminder

The privacy rules under the Health Insurance Portability and Accountability Act (HIPAA) require the Adel-Desoto-Minburn CSD (the "Plan") to periodically send a reminder to participants about the availability of the Plan's Privacy Notice and how to obtain that notice. The Privacy Notice explains participants' rights and the Plan's legal duties with respect to protected health information (PHI) and how the Plan may use and disclose PHI.

To obtain a copy of the Privacy Notice contact plan administrator at 515-993-4283

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

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

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

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

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

You may be eligible for assistance paying your employer health plan premiums. The following information is current as of January 31, 2024. Contact your State for more information on eligibility –

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562

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

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

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

Paperwork Reduction Act Statement

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

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

This guide is intended to describe the eligibility requirements, enrollment procedures, plan highlights, and coverage effective dates for the benefits offered by Adel-DeSoto-Minburn CSD. It is not a legal plan document and does not imply a guarantee of employment or continuation of benefits. While this guide is a tool to answer many of your benefit questions, full details of the plans are contained in the carrier policies, which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will prevail.

23-13203-A 12/23