2027 Benefits Enrollment Guide



Western Iowa Tech Community College



Welcome to Your Benefits

At WITCC, we know that having quality benefits is important to you and your family. That's why we offer a comprehensive, highly competitive benefits package. Use this guide to learn about your benefits, make enrollment decisions that best meet your needs, and take full advantage of your coverage throughout the year.

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Eligibility

All active, regular full-time employees who are scheduled to work 30 or more hours per week are eligible to participate in WITCC's health benefits. You may also cover your eligible dependents under our medical, prescription, dental, vision, and life benefits.

Your eligible dependents may include:

- Legal spouse/domestic partner
- Your child(ren) (up to age 26) and the child(ren) of your covered spouse (up to age 26)
- Children with disabilities who became disabled on or before age 26
- Basic Child Life and Supplemental Child Life - 14 days to age 23.



Choose what's best for you

Your benefits are an important part of your overall compensation, and making informed choices will help you and your family thrive. To get started:

- Review available benefits medical, prescription, dental, vision life and disability, voluntary life and AD&D based on your and your dependents' needs.
- Understand costs (premiums, deductibles, out-of-pocket) to plan your budget.
- Choose the coverage level (individual or family) that fits your situation.

Your enrollment checklist

Navigating a smooth benefits enrollment is easy when you follow this checklist:

- Read your benefits guide to get informed about your options.
- Visit www.benefitsolver.com to review and update your Life/AD&D beneficiaries.
- Attend any informational sessions to learn more.
- Review your personal and dependent information.
- Confirm enrolled dependents are eligible for coverage.
- Compare plans with a spouse/domestic partner's available coverage.
- Enroll by the deadline and remember key dates for changes.

Open Enrollment

Open Enrollment for 2027 is October 15 to November 6, 2026. This is your annual opportunity to make changes to your benefits for the next plan year. The changes you make will go into effect on January 1, 2027. Enrollment information will be provided to you by Human Resources prior to the enrollment period.

*Log into **www.benefitsolver.com** and follow the prompts to review and update beneficiaries.

If you don't enroll: Your current benefits will continue next year — except FSA and HSA contributions, which require action to continue in 2027.

What's changing for 2027

- HSA contribution limits for 2027 increase to $4,500 (individual) and $9,000 (family). Catch-up contribution remains $1,000 for those age 55+.
- FSA contribution limits for 2027 are $2,500 for the medical FSA and $5,000 per household for the Dependent Care FSA.

New Hires

Take action! Learn about your benefit options and enroll within your first 30 days. If you miss this window, you will not have benefits coverage, except for plans and programs that are fully paid by WITCC, such as Basic Life/AD&D and LTD.

Once the enrollment period is over, you cannot change your benefit elections until our next Open Enrollment, unless you experience a qualifying event.

Qualifying Events

When you experience a qualifying event, you have 30 days to change your benefits related to your event. Having a baby, for example, justifies increasing your Dependent Care FSA election but wouldn't justify reducing it. Aging out of eligibility qualifies, too. **When dependents turn 26, they typically lose all benefits coverage through their parents' health insurance plans**.

You will process your change request through the Human Resources' office.

Common qualifying events include:

- Birth, adoption, fostering, or death of a dependent
- Marriage, divorce, or legal separation
- Change in work status for you, your spouse, or a dependent. *Ex.* Spouse starts new job or spouse or child becomes eligible for other coverage
- A dependent aging out of eligibility at age 26
- Gaining or losing Medicare or Medicaid



Medical

WITCC offers 2 comprehensive medical plan options that offer a range of coverage levels and costs. The Copay 500 Plan and the HDHP 2500 plan are both PPO plans. The HDHP is a qualified high-deductible plan which can be paired with a health savings account. Both plans use the Blue Rx Value Plus formula drug list. Here's a look at the coverage you can receive for in-network and out-of-network care under each plan. Benefits are based on a calendar year.

Wellmark

Plan / Wellmark Provider Network	Copay 500 / PPO		HDHP 2500 / PPO	
	In-network	Out-of-network	In-network	Out-of-network
Annual deductible				
Per person / per family	$500 / $1,000		$2,500 / $5,000	
Coinsurance %	20%	30%	NA	
Out-of-pocket maximum				
Per person / per family	$1,000 / $2,000		$2,500 / $5,000	
Medical coverage				
Doctor's office visits* (PCP) Specialist visits* Telemedicine*	$10 copay	Deductible, then coinsurance	Deductible Applies	
Preventive care - Adult and Well-Child	Covered in Full	Deductible, then coinsurance	Covered in Full	Deductible Applies
Outpatient services Inpatient hospital Labs and X-rays	Deductible, then coinsurance	Deductible, then coinsurance	Deductible Applies	
Emergency Room	Deductible, then coinsurance		Deductible Applies	
Infertility treatment	Up to $25,000 lifetime maximum		Up to diagnosis	
	Copay 500 / PPO		**HDHP 2500 / PPO**	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Retail prescription drugs (30-day supply)				
Tier 1 Tier 2 Tier 3	$10 $20 $30		Deductible Applies	
Specialty - Generic and Biosimilar / Preferred / Non-Preferred	$50 / $85 / $100	Not Covered	Deductible Applies	
Prescription Out-Of-Pocket Maximum (Per person / per family)	$250 / $500		$2,500 / $5,000	
Mail-order prescription drugs (90-day supply)				
Tier 1. Tier 2, Tier 3	3 x Retail copay	Not Covered	Deductible Applies	

*Deductible waived for Copay 500 plan

***Note:** High Deductible Health Plans often cover certain preventive medications without requiring you to meet your deductible first. Prescriptions count toward a medical deductible if the insurance plan includes drug costs in the overall deductible. Review plan documents for further details.

Health Savings Account (HSA)

With the High Deductible Health Plan (HDHP), you're eligible to open and contribute money to a Health Savings Account (HSA) through Health Equity. The HSA is a tax-free savings account that you own. Use your HSA to pay for eligible medical, prescription, dental, and vision expenses for you and your family. You can choose to spend the money right away as eligible health expenses come up or save it for the future — you can even use it in retirement.

An HSA offers a triple tax advantage:

1. Contribute money tax-free*	You contribute to your HSA through before-tax payroll deductions from each paycheck.
2. Spend money tax-free*	You own your HSA account, which is tax-free money. Use it to pay for eligible expenses for yourself and your dependents.
3. Grow your money tax-free**	Your HSA funds roll over yearly, earn tax-free interest, and can be invested after reaching a minimum balance for tax-free growth.

*HSA contributions are not subject to federal income tax but are currently subject to state income tax in CA and NJ. Consult your tax advisor for more details. Money in an HSA can be withdrawn tax-free if it is used to pay for qualified health-related expenses. If money is used for ineligible expenses, you will pay ordinary income tax on the amount withdrawn, plus a 20% penalty tax if you withdraw the money before age 65. **Investments involve risk, including the risk of losing money.

2027 contribution limits

The IRS sets annual HSA contribution limits. For 2027, the limits are $4,500 for individual coverage and $9,000 for family coverage, with an extra $1,000 if you're 55 or older.



HSA eligibility

To establish and contribute to an HSA, you:

- Must be enrolled in the HDHP.
- Cannot simultaneously participate in a Health Care FSA, but participation in a Limited Purpose Health Care FSA is allowed.
- Cannot be enrolled in any other medical coverage, including a spouse/domestic partner's plan or Medicare.
- Cannot be claimed as a dependent on someone else's tax return.



Flexible Spending Accounts (FSAs)

A Flexible Spending Account (FSA) is a type of savings account that allows you to set aside pre-tax dollars to pay for eligible out-of-pocket health care and dependent care expenses.

You can participate in the following accounts:

- **Health Care Flexible Spending Account (HCFSA)** Available to employees who are not eligible for an HSA. This account lets you pay for current health care expenses with tax-free money. You can contribute up to $2,500 for the year.*
- **Dependent Care Flexible Spending Account (DCFSA)** Available to all employees regardless of medical plan enrollment. This account lets you pay for childcare and dependent adult care with tax-free money. You can contribute up to $5,000 for the year.

Note: You must enroll in these accounts each Open Enrollment if you want to contribute the next year, even if you already have an account.

*Please note that highly compensated employees as determined by IRC Section 415(c)(3) are capped at $3,600 when contributing to Flexible Spending Accounts for 2027.

How FSAs work:

Choose	Choose your contribution amount **when you enroll**. You can only change it during the year if your personal situation changes, so estimate carefully.
Contribute	Your annual contribution is split **evenly across paychecks**. Health Care FSAs give you the full annual amount upfront, while Dependent Care FSAs only allow access to the funds you've contributed so far.
Spend	Use your FSA **debit card** for eligible health care expenses where accepted or log in to www.healthequity.com to submit payment or reimbursement requests.
Use It Up	Health Care FSAs unused funds **will be forfeited**. Plan carefully!

Dental

Healthy teeth and gums are important to your overall wellness. We offer eligible employees a dental plan through Delta Dental of Iowa. Visit Delta's website to access your dental account.

DELTA DENTAL®	PPO Network	Premier & Non-Participating
Annual deductible (per person)	$15	$25
Calendar-year maximum	$1,000	
Preventive/diagnostic services	$0	$0
Basic services	10% after deductible	20% after deductible
Major services	20% after deductible	20% after deductible
Orthodontia services- Child and Adult	50% after deductible	50% after deductible
Orthodontia Lifetime Maximum	$1,500	

Note: In-network benefits are shown. If you visit an out-of-network provider, you are responsible for any charges above the usual, customary, and reasonable (UCR) limits — refer to benefit summaries for details.

Did you know your dental plan offers CheckUp Plus™

CheckUp Plus™ means Diagnostic and Preventive covered dental service costs do not apply towards your annual calendar-year maximum.

Log into your Delta Dental account to check your coverage and claims. **www.deltadentalia.com**

Money-saving tip

- Remember, you can use your health spending and/or savings account for qualified out-of-pocket dental and vision expenses.
- Receive services from a PPO Provider for lower out-of-pocket costs.
- Check the Delta Provider Networks here: **Dentist Directory | Delta Dental Providers | Dentist Near Me**
- WITCC's plan uses the PPO℠ provider network.

Do you find yourself asking others to repeat themselves? Is there a constant ringing in your ears? If so, your ears could be trying to tell you something.

With your employer's Delta Dental plan, you have access to valuable hearing care discounts. Delta Dental teamed up with **Amplifon** to offer the following discounts:

- Up to $125 off a hearing exam
- Up to $2,995 off per hearing device – includes all major brands and technology levels
- 1 year of free follow-up care
- Free batteries for 2 years
- 3-year warranty for loss, repairs or damage

Learn more **here**. Or get started using these benefits today by calling (855) 491-4339 TTY:711.





Vision

To help keep life in focus, we offer eligible employees vison coverage through Avesis. You can enroll in vision coverage to save money on eligible vision care expenses such as eye exams, glasses, and contact lenses.

avēsis

MATERIALS ONLY PLAN	IN-NETWORK	OUT-OF-NETWORK
Lenses (once per calendar year)	**Once every year**	
Frames (once per calendar year)	**Once every two years**	
Contact lenses (instead of glasses)	**Once every year**	
Materials Copay	$10 Copay	
Frames Allowance	$150 Allowance (up to 20% discount above frame allowance)	Up to $50
Standard Spectacle Lenses		
Single Vision	Covered in Full after $10 Copay	Up to $25
Bifocal	Covered in Full after $10 Copay	Up to $40
Trifocal	Covered in Full after $10 Copay	Up to $50
Lenticular	Covered in Full after $10 Copay	Up to $80
Standard Progressive (Level 1,2)	Covered in Full after $10 Copay	Up to $60
Lens Option Pricing		
Polycarbonate (Single Vision/Multi Focal)	Covered in Full	Up to $10
Standard Scratch Resistant Coating	Covered in Full	Up to $5
Ultra-Violet Screening	Covered in Full	Up to $6
Solid or Gradient Tint	Covered in Full	Up to $4
Standard Anti-Reflective Coating	Covered in Full	Up to $24
Premium Progressives	$140 allowance + up to 20% discount off retail	Up to $79
Other Lens Options	Provider discount up to 20%	Not Applicable
Contact Lenses		
Elective (in lieu of frame and lenses)	$150 allowance	Up to $128
Medically Necessary	Covered In Full	Up to $250

Benefits shown are for in-network providers and are based on negotiated fees - refer to benefit summaries for details.
*Coverage for Refractive Laser Surgery is a onetime/lifetime $150 indemnity allowance and up to 25% provider discount at a Network provider. Go to Avesis's **website** to learn more.

Health & Wellness Support

At WITCC, supporting your health goes far beyond offering traditional coverage. We provide programs and resources to help you feel your best and manage your health care with ease.

Wellness Resources

Our free, confidential wellness services through Wellmark Connect makes it easier and more rewarding to take care of your health. Visit **myWellmark** for more information.

See what you can achieve

The Wellness Program has something for everyone. Do you want to:

- **Gain a clearer picture of your health status?** Take a personal health assessment.
- **Pursue your wellness goals?** Explore the program's online education to learn about the wellness topics that interest you most.
- **Adopt healthier habits?** Make progress one step at a time with help from the program's various resources.

Health Advocacy

Wouldn't it be nice to have an expert by your side as you navigate the health care system? With Health Advocate, you can! Health Advocate provides free, personalized assistance to make health care easier. You and your family members can ask for help with:

- Understanding claims.
- Choosing providers.
- Resolving billing issues.
- And much more.



Save time and money with expert assistance

Visit the Health Advocate **website** or call 866.799.2655 to get started.

Mental Health & Work/Life Support

Employee Assistance Program (EAP)

Our Employee Assistance Program (EAP) supports you in balancing family, work, and personal needs by offering free phone support, guidance, and resources available 24/7 online. It provides referrals for in-person or virtual visits with clinical, legal, and financial professionals. It also includes three free counseling sessions per person per issue, per year, as well as complimentary consultations with financial and legal experts. You also have access to a wide range of online resources and educational materials.

*Available to employees & family members, including parents and parents-in-law, if you're covered under WITCC Long Term Disability.

Reach out for a little help today

It's okay to say you're not okay. The EAP is here to help. Take advantage of this free program to get through life's challenges — big and small.

Phone support: 1-800-854-1446

Online support:
unum.com/lifebalance



Mental Health Resources

In addition to the EAP, you have other options for receiving mental health support.

Your medical plan

Your Wellmark medical plan covers care from licensed mental health professionals, such as therapists, psychologists, and psychiatrists, with costs usually matching those of medical specialist visits. You can find providers on your plan's website or by calling the number on your ID card, and appointments are often available in-person or virtually.

Virtual care

Your Wellmark medical plan lets you access and receive virtual care from mental health professionals who support issues like anxiety, addiction, and depression. If needed, providers can send prescriptions to your local pharmacy. Get started by registering in advance on the **Doctor on Demand website** or downloading the app.

Virtual therapy

Doctor on Demand offers virtual therapy with a wide network of mental health professionals, matching you to a therapist based on your symptoms and preferences. You can receive therapy via live sessions, messaging, or both, with the option to switch therapists if needed. Get started by downloading the app and signing up with your work email.

Life & Disability Insurance

WITCC helps protect your family's financial security from life's unexpected hurdles with life and disability insurance.

Basic life and AD&D insurance

- College paid, automatic coverage through Unum — no enrollment or cost to you.
- AD&D pays 50%–100% of coverage for loss of life, sight, hearing, speech, or limbs due to accident.
- **Tax note:** Coverage over $50,000 is taxable as imputed income.

Beneficiary

Name and update your beneficiary via **www.benefitsolver.com** to ensure benefits are paid as you wish.

Will Prep Services

Online will prep service is backed by online support from licensed attorneys. Follow instructions to create a will that's customized and legally binding. Help is easy to access:

Phone support: 1-800-854-1446

Online support: **unum.com/lifebalance**

What is AD&D insurance?

If you lose your life, sight, hearing, speech, or use of your limb(s) in an accident, AD&D insurance provides additional benefits to help keep your family financially secure. AD&D benefits are paid as a percentage of your coverage amount — from 25% to 100% — depending on the type of loss.

Basic Dependent Life – employee paid

You may purchase additional basic life insurance for your spouse and/or child(ren) in the amount of a flat $5,000.

- Spouse and child(ren) will have the same level of coverage.
    - Ex. Elect $5,000, both spouse and child(ren) are covered at $5,000 under the Basic Dependent Life benefit.
- Employee cost is $2.50 per month for $5,000 in coverage for spouse and/or child(ren).

Disability Coverage

Disability insurance replaces part of your income if illness or injury prevents you from working.

Basic Long-Term Disability	Staff	Faculty	Executive Council
Who pays	College-paid		
Benefit provided	Up to 60% of base monthly salary, up to $5,000 per month	Up to 66.6667% of base monthly salary, up to $6,000 per month	Up to 60% of base monthly salary, up to $7,500 per month
Definition of disability	Unum determines you are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury; and you have a 20% or more loss in your indexed monthly earnings due to the same sickness or injury.		
Maximum benefit duration	Until you're no longer considered disabled or you reach age 65, whichever comes first		
Waiting period	90 days		



Supplemental Life/AD&D Contributions

You receive basic life insurance coverage at no cost from WITCC. Any supplemental life or AD&D insurance you get for yourself or dependents is 100% employee-paid through payroll deductions.

Supplemental life & AD&D insurance

- Optional, employee-paid coverage for you and family through Unum.
- Must cover yourself before dependents.
- Coverage above certain amounts may require evidence of insurability (EOI); coverage up to the Guaranteed Issue (GI) amount does not.

Employee optional life and AD&D insurance

If you want added protection, you can purchase supplemental life and AD&D insurance for yourself. You may elect coverage in $5,000 units up to $100,000.

Spouse optional life and AD&D insurance

You may also purchase life and AD&D insurance for your spouse in $5,000 increments up to $100,000. Cost is based on spouse age.

*Spouse optional life and AD&D insurance may be elected without coverage for yourself if you are covered under the College Basic Life/ADD policy.

Child Optional life insurance

Optional child life insurance provides coverage for child(ren) from 14 days to 6 months at $200 and up to age 23 at $10,000 benefit for each child covered.

Family life and AD&D insurance*

If you want optional life and AD&D coverage for yourself, spouse and child(ren) you may elect Family Life. Employee and spouse can have different coverage amounts.

- Employee and Spouse - $5,000 increments up to $100,000.
- Child(ren) covered as noted below.
- Cost is based on employee age and employee coverage amount.
- Spouse coverage terminates at age 70.
- Age Reduction: reached age 70 – 50%; reached age 75 – 30%; reached age 85 – 20%. All amounts are reduced by the % shown and based on the amount of life insurance in force prior to the attained age.

Supplemental life insurance rates

unum®

	Rates per $1,000 of coverage		
	Options: employee only, employee and child(ren) or spouse only+		Cover yourself, spouse and child
	Employee	Spouse Only+	Family*
Younger than 30	$.090	$.090	$.160
30-39	$.200	$.200	$.310
40-49	$.320	$.320	$.530
50-59	$.690	$.690	$1.070
60+	$1.250	$1.250	$2.110
Children^	$2.50 per month	NA	NA
Guarantee Issue amount	$50,000	$25,000	Employee: $50,000 Spouse: $25,000

*Family Life/AD&D: Cost is based on Employee age and coverage amount.

+Spouse only available if you, the employee, are covered under the College Basic Life/AD&D policy. Terminates at age 70 or when no longer eligible, whichever comes first.

^Child supplemental life is $2.50 per month regardless of the number of children covered.



Contact Information

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

Benefit Plan	Provider	Phone Number	Website
Medical	Wellmark	800 524 9242	www.wellmark.com
Prescription Drugs	Wellmark/CVS Caremark	800 524 9242	www.wellmark.com
Dental	Delta Dental of Iowa	800 544 0718	www.deltadentalia.com
Vision	Avesis	800-828-9341	www.myavesis.com
Health Savings Account	HealthEquity	866 346 5800	www.healthequity.com
Flexible Spending Account(s)	HealthEquity	877 924 3967	www.healthequity.com
Employee Assistance Program	Unum- Health Advocate	800 854 1446	www.unum.com/lifebalance
Life/AD&D Insurance	Unum- Human Resources	712 317 3159	
Disability Insurance	Unum- Human Resources	712 317 3159	
Telemedicine Services	Doctor on Demand	800 997 6196	www.doctorondemand.com
Personal Health Advocate	Health Advocate	866 695 8622	www.healthadvocate.com

Legal notices

Learn more about your rights, workplace safety, and company policies required by law on the next few pages or by visiting Benefitsolver website in the Reference Center.

Learn more

Scan the QR code to visit Benefitsolver where you can login and navigate to the Reference Center to access additional plan information, plan summaries, and more.

Key Benefit Terms

Here are a few key terms to know that will help you understand how your benefits work.

Brand-name drug

A brand-name drug is a medication sold under a specific trade name by a pharmaceutical company. It is usually the original product developed and marketed after research and testing, often protected by a patent, and typically costs more than generic versions.

Coinsurance

Percentage you pay after you've met your annual deductible until you've reached your out-pocket-maximum.

Employee contribution (may be referred to as an employee premium)

The amount you pay through payroll deduction for your health insurance coverage.

Copay

Set dollar amount you pay for common services such as doctor visits or prescription drugs.

Deductible

Amount you pay out of pocket each year before the plan begins to pay for expenses.

Embedded deductible – Copay 500 plan

With an embedded deductible in a family health plan, each person can reach their own deductible and start getting help from the plan to pay medical costs, even if the whole family hasn't reached the family deductible yet. Once the family deductible is met, the plan will help pay for everyone in the family, no matter if they've met their individual deductible or not. This same rule also applies to the yearly out-of-pocket maximum.

Formulary drug (may be referred to as a preferred drug)

A formulary drug is a medication that is included on a health insurance plan's approved list of covered drugs. These drugs are chosen because they are effective and cost-efficient, and the plan usually offers better coverage or lower costs for them compared to non-formulary drugs.

Generic drug

A generic drug is a medication that has the same active ingredients, strength, and quality as a brand-name drug but is usually sold at a lower price. It works the same way in the body and is approved by health authorities as safe and effective.

Key Benefit Terms Continued

In-network provider
Care provided by a participating doctor or health care facility within your plan administrator's network. You will save the most by visiting an in-network provider.

Lifetime maximum
The maximum amount an insurance company will pay for your health care over your lifetime.

Non-embedded deductible (true family deductible) – HDHP 2500 plan
With a non-embedded deductible (also known as a "true family deductible"), there is not an individual deductible for individuals covered on a family medical plan. All family members covered by the plan accumulate eligible expenses toward the plan's family deductible. Once that deductible is met, the plan begins paying coinsurance for all covered members. The same approach applies to the plan's annual out-of-pocket maximum.

Non-formulary drug (may be referred to as a non-preferred drug)
A non-formulary drug is a medication that is not included on a health insurance plan's approved list of covered drugs. These drugs usually have higher out-of-pocket costs or may require special approval before the plan will cover them.

Out-of-network provider
Any care received outside the plan administrator's provider network. Your share of the costs will be higher in most cases.

Out-of-pocket maximum
The most you pay each year for eligible medical and prescription drug expenses.

Premium (see "Employee contribution")

Preventive care
Annual physicals, routine checkups, and screenings to identify health issues before they become serious. Preventive care is usually covered 100% in-network by your plan. Many preventive benefits are based on age and frequency.

See the Carrier SBC's, Coverage Manual for more information. Or visit **myWellmark to review your plan coverage. You may also contact Wellmark at the phone # on your ID Card.

Frequently Asked Questions

Q: Are prescription drugs included in my medical plan?
A: Yes, through retail pharmacies and mail-order prescriptions.

Q: Can I have other health coverage along with coverage through WITCC?
A: Yes, you can have dual coverage — our plan plus another (e.g., a spouse/domestic partners') secondary group health. Coordination of benefits (COB) applies:

- Our plan is primary for you; file claims here first. If costs remain, file with your secondary insurer. For spouses/domestic partners covered by both plans, our plan is secondary.
- Dependent children are covered first by the parent whose birthday comes earlier in the year; the other plan is secondary. Court orders may affect this if parents are separated or divorced.
- Only eligible expenses under the plans are considered for COB; amounts beyond coverage are excluded.

Q: Do I have to enroll to receive benefits?
A: Some benefits start automatically without an enrollment when you're hired, but elective benefits require enrollment within 30 days of hire or during Open Enrollment. After your initial election, you can only change benefits annually during Open Enrollment or after a qualifying event.

This is a passive Open Enrollment. If you don't make new elections by Friday, November 6, 2026 your current benefits will continue except for FSAs, which requires yearly enrollment. After Open Enrollment closes, changes are only allowed with a qualifying event. To change benefits or contribute to FSAs next year, you must actively enroll during Open Enrollment.

Q: How do I add my dependents to coverage?
A: Enroll your dependents by contacting Human Resources.

Q: What happens if I miss the deadline to enroll in WITCC's benefit programs?
A: If you don't make your benefit elections within 30 days after your date of hire, or by the Open Enrollment deadline, you won't be able to enroll or change coverage until the next Open Enrollment period unless you have a qualifying event.

Q: When do I receive my medical, dental, and vision ID cards?
A: Once you submit your enrollment information, your medical card(s) should arrive within three to four weeks. Only those who are new to the plan or changing plans will receive new medical or dental cards. You will not receive a vision ID card. Electronic ID cards often can be downloaded from the carriers' websites.

Q: How do I enroll for benefits?
A: All benefits enrollment is done through the Human Resources office. You can review and update beneficiaries by logging in to your account at www.Benefitsolver.com.

Q: How do I know if my provider is in the network?
A: Check the plan's website or call the provider directly. Remember, be sure to ask them whether they're a "contracted provider" with our insurance carrier.

Q: How do I pay for my benefits?
A: Employee contributions are deducted from each paycheck year-round, with WITCC also contributing. Most deductions are pretax, lowering your taxable income and reducing federal and state taxes withheld.

Q: Is there anything I can do if I have a doctor I like and they're an out-of-network provider?
A: You can talk to your doctor and ask them if they would be willing to become a contracted provider with the insurance carrier's provider network.

Q: What if I get married, divorced, or add a child in my family during the plan year?
A: These are considered qualifying events; therefore, you must notify the Human Resources department within 30 days of the event to change your benefits. Otherwise, you will have to wait until the next Open Enrollment period to change your benefit options or coverage levels. You may also be required to show official documentation as proof of the qualifying event, such as a marriage license, birth certificate, or court papers.

Q: What is an annual benefits enrollment period?
A: It's the time of year you may add, drop, or change your coverage for certain pretax benefit options.

Q: What is an Explanation of Benefits (EOB)?
A: It's a statement provided to a plan participant explaining how a claim was paid or why payment was denied. Always review your EOB statements for accuracy. If you have a question about an EOB, or see an error, contact the provider directly.

Q: Where can I obtain detailed information about the plans available to me?
A: See your Summary Plan Description (SPD), Carrier Coverage Manuals and Benefit Certificates. Contact Human Resources for a copy.

Q: When can I continue coverage under COBRA?
A: You and/or your dependents are eligible to continue group health care under COBRA if coverage is lost because:

- You leave the College for any reason other than “gross misconduct.”
- Your work hours are reduced.
- You die.
- You enroll in Medicare prior to electing COBRA.
- You divorce.
- Your dependent loses dependent status, such as turning age 26.

Q. When does coverage end?
A: It depends on your specific plan. Typically, coverage ends the last day of your employment month. You may elect COBRA to extend medical, dental, vision, and Health Care FSA benefits. COBRA details will be sent after termination; you have 60 days to decide.

Once you enroll in Medicare or Medicaid, your insurance typically ends on the last day of the month you sign up. If your employer has 20 or more employees, your group insurance coverage is usually primary, and you can delay Medicare Part B enrollment without any penalty until you retire or lose your employer coverage. If your employer has fewer than 20 employees, Medicare becomes your primary insurance, and it's often best to enroll in Part B at 65. Since Medicare rules can get complicated, it's wise to check with your benefits administrator, or a licensed insurance agent or financial advisor to make an informed choice for your situation.

Q: When does coverage begin?
A: Coverage starts 1st of the month following 30 days of employment.

Q: Who is eligible for coverage?
A: Active full-time employees, working 30 or more hours per week, plus their dependents.

Q: Why do I pay for some benefits with pretax money?
A: Paying for certain optional benefits with pretax money lowers your taxable income; therefore, you pay taxes on a smaller amount. IRS code specifies the value of any life insurance coverage provided to employees exceeding $50,000 must be considered imputed income.

This guide is intended to describe the eligibility requirements, enrollment procedures, plan highlights, and coverage effective dates for the benefits offered by WITCC. 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 Summary Plan Descriptions (SPDs), which govern the plans' operation. The noted plan changes in this guide may serve as a Summary of Material Modifications (SMM) to the SPD. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will prevail.

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XX-XXXXX-X X/XX

Summary of Benefits & Coverage (SBC's)

- **Copay 500**
- **HDHP 2500 NE PPO**

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Wellmark

Coverage Period: 07/01/2026 – 06/30/2027
Coverage for: Single & Family | Plan Type: PPO

Premium Copay 500 PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.wellmark.com or call 1-866-807-9430. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-866-807-9430 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** person/**$1,000** family per calendar year.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care, in-network independent labs, in-network routine vision exams, in-network prosthetic limbs, mammograms and services subject to health and drug card copayments are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No. There are no other deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Health: **$1,000** person/**$2,000** family per calendar year. Drug Card: **$250** person/ **$500** family per calendar year. The In-Network health and drug card out-of-pocket maximum amounts accumulate separately.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.wellmark.com or call 1-866-807-9430 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why this Matters:
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay per date of service	30% coinsurance	------None------
	Specialist visit	$10 copay per date of service	30% coinsurance	Hearing exams are covered according to ACA guidelines.
	Preventive care/screening/ immunization	No charge	30% coinsurance	One preventive exam and one mammogram per calendar year. Well-child care is covered to age 7. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance	For a test in a provider's office or clinic, your cost is included in the cost-share listed above. In-network independent labs for mental health/chemical dependency services are not subject to coinsurance.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	For a test in a provider's office or clinic, your cost is included in the cost-share listed above.

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

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is at www.wellmark.com/prescriptions.	Tier 1	$10 copay per prescription	$10 copay per prescription	Refer to your Blue Rx Value Plus Drug List to determine the tier that applies to a covered drug. For out-of-network prescription drugs, you may be balance billed. 1 copay for 30-day supply. 3 copays for 90-day supply (retail and mail order). Specialty drugs are covered only when obtained through the Specialty Pharmacy Program. Specialty drugs on the PrudentRx drug list (found at Wellmark.com) will have 30% coinsurance. If you enroll with PrudentRx, you will have $0 member cost-share for drugs on the PrudentRx drug list. See wellmark.com/prescriptions for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your plan.
	Tier 2	$20 copay per prescription	$20 copay per prescription	
	Tier 3	$30 copay per prescription	$30 copay per prescription	
	Specialty drugs	Generic: $50 copay per prescription Preferred: $85 copay per prescription Non-preferred: $100 copay per prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	------None------
	Physician/surgeon fees	20% coinsurance	30% coinsurance	------None------

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

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	For emergency medical conditions treated out-of-network, it is likely you may not be balance billed pursuant to the federal rules developed for implementation of the No Surprises Act.
	Emergency medical transportation	20% coinsurance	20% coinsurance	For covered non-emergent situations, out-of-network ground ambulance services are NOT reimbursed at the in-network level. You may be balance billed for any out-of-network service as established under the rules developed for implementation of the No Surprises Act.
	Urgent care	$10 copay per date of service for facility and physician(s) combined	30% coinsurance	------None------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	------None------
	Physician/surgeon fees	20% coinsurance	30% coinsurance	------None------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $10 copay per date of service Facility: 20% coinsurance	30% coinsurance	------None------
	Inpatient services	20% coinsurance	30% coinsurance	------None------

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

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you are pregnant	Office visits	20% coinsurance	30% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for preventive services. For any in-network services that fall outside of routine obstetric care, the office visit benefits shown above may apply.
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	Benefits shown reflect OB/GYN practitioner services which are typically globally billed at time of delivery for pre-natal, post-natal and delivery services.
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	------None------
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	------None------
	Rehabilitation services	Office: $10 copay per date of service Facility: 20% coinsurance	30% coinsurance	------None------
	Habilitation services	Office: $10 copay per date of service Facility: 20% coinsurance	30% coinsurance	------None------
	Skilled nursing care	20% coinsurance	30% coinsurance	------None------
	Durable medical equipment	20% coinsurance	30% coinsurance	Orthopedic shoes, shoe inserts and accessories are covered. Trusses for back or hernia support are covered.
	Hospice services	20% coinsurance	30% coinsurance	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.
If your child needs dental or eye care	Children's eye exam	No charge	30% coinsurance	One routine vision exam per calendar year.
	Children's glasses	Not covered	Not covered	------None------
	Children's dental check-up	Not covered	Not covered	------None------

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

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Custodial care - in home or facility
- Dental care - Adult
- Dental check-up
- Extended home skilled nursing
- Glasses
- Hearing aids
- Long-term care
- Routine foot care
- Some pharmacy drugs are not covered
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Applied Behavior Analysis therapy
- Bariatric surgery
- Chiropractic care
- Infertility treatment ($25,000 LTM)
- Most coverage provided outside the U.S.
- Private-duty nursing - short term intermittent home skilled nursing
- Routine eye care - Adult (one vision exam per calendar year)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, you can contact: Wellmark at 1-866-807-9430, Iowa Insurance Division at 515-654-6600, or Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

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

About These Coverage Examples:

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

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

The plan's overall deductible	$500
PCP copayment	$10
Hospital(facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$60
Coinsurance	$400
What isn't covered	
Limits or exclusions	**$60**
The total Peg would pay is	**$1,020**

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

The plan's overall deductible	$500
Specialist copayment	$10
Hospital(facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$50
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	**$20**
The total Joe would pay is	**$470**

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

The plan's overall deductible	$500
Specialist copayment	$10
Hospital(facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$60
Coinsurance	$300
What isn't covered	
Limits or exclusions	**$0**
The total Mia would pay is	**$860**

The amounts shown in the maternity claim example above are based on amounts using a single per person deductible. Some plans may actually apply a two-person or family deductible to maternity services for the mother and newborn baby.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Wellmark Language Assistance

Discrimination is against the law

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

Wellmark

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

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

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

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

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

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

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

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

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

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

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

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية، المجانية. اتصل بالرقم ٢٤٢٩-٤٢٥-٠٠٨ أو (خدمة الهاتف النصي: ٨٨٨-١٨٧-٢٦٢٤).

ສ່ວນ, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານ ໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ຫາ. (TTY: 888-781-4262.)

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

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

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

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

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

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

တtill:ဒုးသူဉ်ညါ–နမ့ါကတိၤကညီကျိာ်,ကျိာ်တtill်မၤစၢၤတtill်ဖံးတtill်မၤတဖဉ်,လၢတဘဉ်လာ်ဘူးလဲ,အိဉ်လၢနှဂီၢ်လီၤ.ဆဲးကျိးဆူ ၈၀၀–၅၂၄–၉၂၄၂မ့တမ့ါ(TTY:၈၈၈–၇၈၁–၄၂၆၂)တကွာ်.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि निःशुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ । 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस् ।

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

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

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

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

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

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Coverage Period: 07/01/2026 – 06/30/2027
Coverage for: Single & Family | Plan Type: PPO HDHP

Value HDHP 2500 PPO NE

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.wellmark.com or call 1-866-807-9430. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-866-807-9430 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,500** person/**$5,000** family per calendar year.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Routine vision exams and in-network preventive care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No. There are no other deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$2,500** person/**$5,000** family per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.wellmark.com or call 1-866-807-9430 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	0% coinsurance	------None------
	Specialist visit	0% coinsurance	0% coinsurance	Hearing exams are covered according to ACA guidelines.
	Preventive care/screening/ immunization	No charge	0% coinsurance	One preventive exam and one mammogram per calendar year. Well-child care is covered to age 7. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	0% coinsurance	------None------
	Imaging (CT/PET scans, MRIs)	0% coinsurance	0% coinsurance	------None------

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

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is at www.wellmark.com/prescriptions.	Tier 1	0% coinsurance	0% coinsurance	Refer to your Blue Rx Value Plus Drug List to determine the tier that applies to a covered drug. You pay the discounted cost of your prescription drugs until your deductible is met. For out-of-network prescription drugs, you may be balance billed. 30-day supply for prescription drugs. 90-day prescription maximum. Specialty drugs are covered only when obtained through the Specialty Pharmacy Program. Specialty drugs on the PrudentRx drug list (found at Wellmark.com) will have 30% coinsurance. If you enroll with PrudentRx, you will have $0 member cost-share for drugs on the PrudentRx drug list once your deductible is met. See wellmark.com/prescriptions for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your plan.
	Tier 2	0% coinsurance	0% coinsurance	
	Tier 3	0% coinsurance	0% coinsurance	
	Specialty drugs	0% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	0% coinsurance	------None------
	Physician/surgeon fees	0% coinsurance	0% coinsurance	------None------

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

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	For emergency medical conditions treated out-of-network, it is likely you may not be balance billed pursuant to the federal rules developed for implementation of the No Surprises Act.
	Emergency medical transportation	0% coinsurance	0% coinsurance	For covered non-emergent situations, out-of-network ground ambulance services are NOT reimbursed at the in-network level. You may be balance billed for any out-of-network service as established under the rules developed for implementation of the No Surprises Act.
	Urgent care	0% coinsurance	0% coinsurance	------None------
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	0% coinsurance	------None------
	Physician/surgeon fees	0% coinsurance	0% coinsurance	------None------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	0% coinsurance	------None------
	Inpatient services	0% coinsurance	0% coinsurance	------None------
If you are pregnant	Office visits	0% coinsurance	0% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	0% coinsurance	0% coinsurance	Benefits shown reflect OB/GYN practitioner services which are typically globally billed at time of delivery for pre-natal, post-natal and delivery services.
	Childbirth/delivery facility services	0% coinsurance	0% coinsurance	------None------

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

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	0% coinsurance	0% coinsurance	------None------
	Rehabilitation services	0% coinsurance	0% coinsurance	------None------
	Habilitation services	0% coinsurance	0% coinsurance	------None------
	Skilled nursing care	0% coinsurance	0% coinsurance	------None------
	Durable medical equipment	0% coinsurance	0% coinsurance	------None------
	Hospice services	0% coinsurance	0% coinsurance	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.
If your child needs dental or eye care	Children's eye exam	No charge	0% coinsurance	One routine vision exam per calendar year.
	Children's glasses	Not covered	Not covered	------None------
	Children's dental check-up	Not covered	Not covered	------None------

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

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Custodial care - in home or facility
- Dental care - Adult
- Dental check-up
- Extended home skilled nursing
- Glasses
- Hearing aids
- Long-term care
- Routine foot care
- Some pharmacy drugs are not covered
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Applied Behavior Analysis therapy
- Bariatric surgery
- Chiropractic care
- Infertility treatment (excludes some services)
- Most coverage provided outside the U.S.
- Private-duty nursing - short term intermittent home skilled nursing
- Routine eye care - Adult (one vision exam per calendar year)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, you can contact: Wellmark at 1-866-807-9430, Iowa Insurance Division at 515-654-6600, or Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

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

About These Coverage Examples:

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

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

The plan's overall deductible	$2,500
PCP coinsurance	0%
Hospital(facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	**$60**
The total Peg would pay is	**$2,560**

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

The plan's overall deductible	$2,500
Specialist coinsurance	0%
Hospital(facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	**$20**
The total Joe would pay is	**$2,520**

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

The plan's overall deductible	$2,500
Specialist coinsurance	0%
Hospital(facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	**$0**
The total Mia would pay is	**$2,500**

The amounts shown in the maternity claim example above are based on amounts using a single per person deductible. Some plans may actually apply a two-person or family deductible to maternity services for the mother and newborn baby.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Employer Notices

Important notice to employees from Western Iowa Tech Community College 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 Western Iowa Tech Community College medical plan are expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2027. 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 2027 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 Western Iowa Tech Community College 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 Western Iowa Tech Community College 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 2027. This is called creditable coverage. Coverage under one of these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

Copay 500, HDHP 2500 NE

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the Western Iowa Tech Community College 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 Western Iowa Tech Community College coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment or other qualifying event, or otherwise become newly eligible to enroll in the Western Iowa Tech Community College plan mid-year, assuming you remain eligible.

You should know that if you waive or leave coverage with Western Iowa Tech Community College 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 Western Iowa Tech Community College coverage changes, or upon your request.

For more information about your options under Medicare prescription drug coverage

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

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

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

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

For more information about this notice or your prescription drug coverage, contact:
Western Iowa Tech Community College
4647 Stone Ave.
Sioux City, IA 51106

January 1, 2027

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

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

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

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

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

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

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp or Health Insurance Premium Payment Program/Cost Avoidance | DHCS Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**ILLINOIS - Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Illinois Medicaid Premium Assistance Information Medicaid application website: https://abe.illinois.gov HIPP Hotline Number: 217-524-8268 HIPP Email: hfs.boc.hipp@illinois.gov
INDIANA – Medicaid	**IOWA – Medicaid and CHIP (Hawki)**
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584	Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KANSAS – Medicaid	**KENTUCKY – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid	MAINE – Medicaid
Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084	Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP	**MINNESOTA – Medicaid**
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
MISSOURI – Medicaid	**MONTANA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid	**NEVADA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov ACCESSNebraska Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	Medicaid Website: https://www.nj.gov/humanservices/dmahs/clients/medicaid/ or NJ FamilyCare/Medicaid | Division of Medical Assistance and Health Services Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825 or (866)-614-6005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742

OREGON – Medicaid	PENNSYLVANIA – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP	**SOUTH CAROLINA – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**TEXAS – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	**VERMONT– Medicaid**
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924 or 1-855-242-8282	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Website: https://bms.wv.gov/ https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid	
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-855-294-2127	

To see if any other states have added a premium assistance program since July 31, 2026, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 5/31/2029)

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 712-274-6400 ext 1406.

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 712-274-6400 ext 1406.

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

The Washington County Hospital and Clinics' 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 contact Western Iowa Tech Community College Human Resources Department with the necessary information regarding the dependent as soon as the need for the leave is recognized. In addition, contact your child's health plan/employer to see if any state laws requiring extended coverage may apply to his or her benefits.

Marketplace/Exchange Notice

Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

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

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

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 10.22% 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 10.22% for 2027[1] of the employee's household income.

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

[1] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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.

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. Confirm the deadline with your employer or your employment-based health plan.

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

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Human Resources at 712-274-6400 x 1406.

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name: Western Iowa Tech Community College	4. Employer Identification Number (EIN): 42-0926922	
5. Employer address: 4647 Stone Avenue	6. Employer phone number: (712)-274-6400	
7. City Sioux City	8. State: IA	9. Zip code: 51106
10. Who can we contact about employee health coverage at this job? Jackie Plendl		
11. Phone number (if different from above) 712-247-6400 x 1406	12. Email address: Jackie.plendl@witcc.edu	

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

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

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

    ☒ Some employees. Eligible employees are:

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

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

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

  - ☐ We do not offer coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

Western Iowa Tech Community College HIPAA Privacy Notice

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by Western Iowa Tech Community College health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of these plans: **Copay 500, HDHP 2500 NE**. The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

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

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

How the Plan may use or disclose your health information

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

Treatment includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.

Payment includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.

Health care operations include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

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

How the Plan may share your health information with Western Iowa Tech Community College

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to Western Iowa Tech Community College for plan administration purposes. Western Iowa Tech Community

College may need your health information to administer benefits under the Plan. Western Iowa Tech Community College agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Human Resources, Payroll & Benefits are the only Western Iowa Tech Community College employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and Western Iowa Tech Community College, as allowed under the HIPAA rules:

The Plan, or its insurer or HMO, may disclose "summary health information" to Western Iowa Tech Community College, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.

The Plan, or its insurer or HMO, may disclose to Western Iowa Tech Community College information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

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

Other allowable uses or disclosures of your health information

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

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

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects

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

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

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

How the plan will treat certain SUD treatment information

The Plan is not a federally assisted substance use disorder diagnosis, treatment or referral program that is covered by 42 CFR Part 2 (a "Part 2 Program") and does not create and does not typically maintain any records that are subject to 42 CFR Part 2. If the Plan does receive any Part 2 Program records pursuant to your written consent for claim administration and payment, the records will only be used and disclosed in accordance with HIPAA and your consent. In no event will the Plan use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings against you, unless authorized by your written consent or a court order accompanied by a subpoena or other legal requirement compelling disclosure after you received notice and an opportunity to respond.

Your individual rights

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

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

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

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

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

Right to receive confidential communications of your health information

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

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

Right to inspect and copy your health information

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

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

The access or copies you requested

A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint

A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

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

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

Right to amend your health information that is inaccurate or incomplete

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

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

Make the amendment as requested

Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint

Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

Right to receive an accounting of disclosures of your health information

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

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

For treatment, payment, or health care operations

To you about your own health information

Incidental to other permitted or required disclosures

Where authorization was provided

To family members or friends involved in your care (where disclosure is permitted without authorization)

For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances

As part of a “limited data set” (health information that excludes certain identifying information)

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

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

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

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

Changes to the information in this notice

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on **July 1, 2026**. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan’s privacy policies described in this notice, you will be provided with a revised privacy notice via e-mail.

Complaints

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won’t be retaliated against for filing a complaint. To file a complaint, contact your Human Resources Department.

Contact

For more information on the Plan’s privacy policies or your rights under HIPAA, contact Jackie Plendl at 712-274-6400 x 1406.

Model COBRA Continuation Coverage General Notice

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.”

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Western Iowa Tech Community College, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee’s spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- 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: Washington County Hospital & Clinics’ Human Resources Department with all documentation that would be relevant to the situation stated above.

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. **You must provide this notice to the college’s Human Resources Department as the qualifying event has occurred. You must provide them the appropriate legal documentation that would allow for the qualifying event that would allow extension of your COBRA.**

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.**

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 period3 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**.

[3] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

(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**.

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

Western Iowa Tech Community College
4647 Stone Ave.
Sioux City, IA 51106
(712)-274-6400 x 1406

Notice of Special Enrollment Rights for Medical/Health plan coverage

As you know, if you have declined enrollment in Western Iowa Tech Community College' 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.

Western Iowa Tech Community College 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 Western Iowa Tech Community College 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.

Provider-Choice rights notice

The Wellmark plans generally allow 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, visit www.wellmark.com or call 1-800-524-9242.

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

You do not need prior authorization from Wellmark 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, visit www.wellmark.com or call 1-800-524-9242.

No Surprises Act notice

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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, like a copayment, coinsurance, or deductible. You may have additional 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" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays 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 plan's deductible or 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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're 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 they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). 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 can 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 types of 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 out-of-network care. You can choose a provider or facility in your plan's network.

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

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:

- Cover emergency services without requiring you to get approval for services in advance (also known as "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 in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact U.S. Department of Health and Human Services. The federal phone number for information and complaints is: 1-800-985-3059. Visit No Surprises Act | CMS for more information about your rights under federal law.