COLLINS-MAXWELL

ELEMENTARY SCHOOL

2024-25

EMPLOYEE BENEFITS GUIDE

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This benefit summary describes the benefit plans available to you as an employee of Collins-Maxwell. The details of these plans are contained in the official plan documents that have been provided to you by your employer, including some insurance contacts. This summary is meant only to cover the highlights of each plan. It does not contain all the details that are included in your summary plan description as described by the Employee Retirement Income Security Act (ERISA).

If there is ever a question about one of these plans, or if there is a conflict between the information in this summary and the formal language of the plan documents, the formal wording in the plan documents will govern. Please note that the benefits described in the summary may be changed at any time and do not represent a contractual obligation on the part of Collins-Maxwell CSD.

CHIP NOTICE

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 Collins-Maxwell CSD, 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 on the following page, 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, dial **1-877-KIDS NOW**, or visit **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 January 31, 2024. Contact your State for more information on eligibility.

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

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

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

State	Website/E-mail	Phone
Alabama (Medicaid)	**http://www.myalhipp.com/**	1-855-692-5447
Alaska (Medicaid)	*Premium Payment Program:* **http://myakhipp.com/** *Medicaid Eligibility:* **https://health.alaska.gov/dpa/Pages/default.aspx** *E-mail:* **CustomerService@MyAKHIPP.com**	1-866-251-4861
Arkansas (Medicaid)	**http://myarhipp.com/**	1-855-692-7447
California (Medicaid)	**http://dhcs.ca.gov/hipp** **hipp@dhcs.ca.gov**	916-445-8322 916-440-5676 (fax)
Colorado (Medicaid and CHIP)	*Medicaid:* **https://www.healthfirstcolorado.com/** *CHIP:* **https://hcpf.colorado.gov/child-health-plan-plus** *HIBI:* **https://www.mycohibi.com/**	1-800-221-3943 1-800-359-1991 1-855-692-6442 State relay 711
Florida (Medicaid)	**https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html**	1-877-357-3268

State	Website/E-mail	Phone
Georgia (Medicaid)	*HIPP:* **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp** *CHIPRA:* **https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra**	678-564-1162, press 1 678-564-1162, press 2
Indiana (Medicaid)	*Healthy Indiana Plan for low-income adults 19-64:* **http://www.in.gov/fssa/hip/** *All other Medicaid:* **https://www.in.gov/medicaid**	1-877-438-4479 1-800-457-4584
Iowa (Medicaid and CHIP)	*Medicaid:* **https://dhs.iowa.gov/ime/members** *CHIP:* **http://dhs.iowa.gov/Hawki** *HIPP:* **https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp**	1-800-338-8366 1-800-257-8563 1-888-346-9562
Kansas (Medicaid)	**https://www.kancare.ks.gov/**	1-800-967-4660 HIPP: 1-800-967-4660
Kentucky (Medicaid and CHIP)	*Medicaid:* **https://chfs.ky.gov/agencies/dms** *KI-HIPP:* **https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.apsx** *KI-HIPP E-mail:* **KIHIPP.PROGRAM@ky.gov** *KCHIP:* **https://kynect.ly.gov**	 1-855-459-6328 1-877-524-4718
Louisiana (Medicaid)	**www.medicaid.la.gov** **www.ldh.la.gov/lahipp**	1-888-342-6207 1-855-618-5488
Maine (Medicaid)	**https://www.maine.gov/dhhs/ofi/applications-forms** **https://www.mymaineconnection.gov/benefits/s/?language=e n_US**	*Enroll:* 1-800-442-6003 *Private HIP:* 1-800-977-6740 TTY: Maine relay 711
Massachusetts (Medicaid and CHIP)	**https://www.mass.gov/masshealth/pa** **Email: masspremassistance@accenture.com**	1-800-862-4840 TTY: 711
Minnesota (Medicaid)	**https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp**	1-800-657-3739
Missouri (Medicaid)	**http://www.dss.mo.gov/mhd/participants/pages/hipp.htm**	573-751-2005
Montana (Medicaid)	**http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP** **HHSHIPPProgram@mt.gov**	1-800-694-3084
Nebraska (Medicaid)	**http://www.ACCESSNebraska.ne.gov**	1-855-632-7633 *Lincoln:* 402-473-7000 *Omaha:* 402-595-1178
Nevada (Medicaid)	**http://dhcfp.nv.gov/**	1-800-992-0900
New Hampshire (Medicaid)	**https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program**	603-271-5218 or 1-800-852-3345, ext. 5218
New Jersey (Medicaid and CHIP)	*Medicaid:* **http://www.state.nj.us/humanservices/dmahs/clients/medicaid/** *CHIP:* **http://www.njfamilycare.org/index.html**	*Medicaid:* 609-631-2392 *CHIP:* 1-800-701-0710
New York (Medicaid)	**https://www.health.ny.gov/health_care/medicaid/**	1-800-541-2831
North Carolina (Medicaid)	**https://medicaid.ncdhhs.gov/**	919-855-4100
North Dakota (Medicaid)	**https://www.hhs.nd.gov/healthcare**	1-844-854-4825
Oklahoma (Medicaid and CHIP)	**http://www.insureoklahoma.org**	1-888-365-3742
Oregon (Medicaid)	**http://healthcare.oregon.gov/Pages/index.aspx**	1-800-699-9075
Pennsylvania (Medicaid and CHIP)	Medicaid: **https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx** *CHIP:* **https://www.dhs.pa.gov/chip/pages/chip.aspx**	*Medicaid:* 1-800-692-7462 *CHIP:* 1-800-986-KIDS (5437)
Rhode Island (Medicaid and CHIP)	**http://www.eohhs.ri.gov/**	1-855-697-4347 or 401-462-0311 (Direct RIte)
South Carolina (Medicaid)	**https://www.scdhhs.gov**	1-888-549-0820
South Dakota (Medicaid)	**http://dss.sd.gov**	1-888-828-0059
Texas (Medicaid)	**https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program**	1-800-440-0493
Utah (Medicaid and CHIP)	*Medicaid:* **https://medicaid.utah.gov/** *CHIP:* **http://health.utah.gov/chip**	1-877-543-7669
Vermont (Medicaid)	**https://dvha.vermont.gov/members/medicaid/hipp-program**	1-800-250-8427
Virginia (Medicaid and CHIP)	**https://coverva.dmas.virginia.gov/learn/premiumassistance/famis-select** **https://coverva.dmas.virginia.gov/learn/premiumassistance/health-insurance-premium-payment-hipp-programs**	1-800-432-5924
Washington (Medicaid)	**https://www.hca.wa.gov/**	1-800-562-3022
West Virginia (Medicaid)	**https://dhhr.wv.gov/bms/** **http://mywvhipp.com/**	*Medicaid:* 304-558-1700 *CHIP:* 1-855-699-8447
Wisconsin (Medicaid and CHIP)	**https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm**	1-800-362-3002
Wyoming (Medicaid)	**https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/**	1-800-251-1269

WELCOME!

WE ARE COMMITTED to providing competitive benefit programs that are flexible enough to meet your individual needs. Our comprehensive benefits are carefully designed to give you the tools you need to keep you and your family healthy, provide financial protection in the event of unforeseen circumstances and help you build long-term security for retirement.

Getting the most from your benefits is up to you. You know your family, your goals and your lifestyle best.
This benefits guide was designed to answer some of the basic questions you may have about your benefits. Please take the time to review this guide to make sure you understand the benefits that are available to you and your family and be sure to act before the enrollment deadline.

OPEN ENROLLMENT: TAKE ACTION!

Open Enrollment: April 29th, 2024 through May 12th, 2024

Coverage Effective Dates: July 1st, 2024 through June 30th, 2024

This Open Enrollment is an **active enrollment**, meaning all employees must log-in to the EASE Benefit Platform portal to review elections and make any necessary changes. Once you make your benefit elections, these choices remain in effect until the next annual open enrollment unless you have a qualified status change.

If you do not enroll, your benefits will be waived beginning **July 1, 2024** and you will not be able to enroll until the next Open Enrollment, unless you experience a Qualifying Life Event (QLE).

ELIGIBILITY

BENEFIT ELIGIBILITY

You and your eligible family members may participate in the 2024 employee benefits program if you're a regular, full-time employee working **30** hours per week.

DEPENDENT ELIGIBILITY

You may also enroll the following dependents in our group benefit plans:

- Your legal spouse or domestic partner
- You eligible children up to age 26* for medical, dental and vision coverage; your unmarried full-time student beyond age 26
- A child under the age of 26 who is your natural child, stepchild, legally adopted child, or child for whom you have obtained
  legal guardianship
- Unmarried children of any age if totally disabled and claimed as a dependent on your federal income tax return (documentation of handicapped status must be provided)

NEW-HIRE ELIGIBILITY

New hires can join the plan the **first of the month following contracted start date**.

**Enrolled children lose coverage when they turn 26 and will be mailed COBRA enrollment information.*

QUALIFYING LIFE EVENT

Your benefit elections made during Open Enrollment will be effective **July 1, 2024** . You may not make changes to your elections unless you experience
a qualifying life event, including change in legal marital status (marriage, divorce, death of spouse), change in dependents (birth, adoption), change in employment status (termination, part-time), or your spouse's Open Enrollment.

30
days

IMPORTANT

If you need to make a change before the next Open Enrollment period due to a change in status, you must submit the required documentation WITHIN 30 DAYS of the qualifying life change event.

Login to **collins-maxwell.ease.com** to process a Qualifying Life Event.

EMPLOYEE CONTRIBUTIONS

Basic Coverages		Monthly Premium	Employee Pays	Employer Pays
Medical				
$500 PPO Plan				
	Single:	$642.64	$0.00	$642.64
	Employee/Spouse:	$1,477.31	$834.67	$642.64
	Employee/Children:	$1,477.31	$834.67	$642.64
	Family:	$1,477.31	$834.67	$642.64
$1,000 PPO Plan				
	Single:	$621.64	$0.00	$621.64
	Employee/Spouse:	$1,436.31	$793.67	$642.64
	Employee/Children:	$1,436.31	$793.67	$642.64
	Family:	$1,436.31	$793.67	$642.64
Dental				
	Single:	$27.73	$13.73	$14.00
	Employee/Spouse:	$84.48	$70.48	$14.00
	Employee/Child(ren):	$84.48	$70.48	$14.00
	Family:	$84.48	$70.48	$14.00
Life and AD&D (Employee only)		N/A	$0	100%
LTD		N/A	$0	100%
Voluntary Products		**Monthly Premium**	**Employee Pays**	**Employer Pays**
Vision				
	Single:	$6.32	$6.32	$0.00
	Employee/Spouse:	$16.00	$16.00	$0.00
	Employee/Child(ren):	$16.00	$16.00	$0.00
	Family:	$16.00	$16.00	$0.00
Flexible Spending Accounts		N/A	100%	0%
Voluntary Life:		Varies	100%	0%
Voluntary Accident Insurance:		Varies	100%	0%

MEDICAL PLAN

Collins-Maxwell CSD's medical options all provide coverage for the same types of expenses, such as doctor's office visits, preventive care, prescription drugs, and hospitalization. You choose the option that makes the most sense for you and your family based on your needs and what you want to pay for coverage.

These plans are administered through Wellmark and utilize the Blue Choice POS network. Find a provider: 'browse list of plans' select Wellmark Blue POS (Blue Choice). The drug formulary is Blue Rx Complete.

Point-of-Service Network (POS) – Iowa based network

Point-of-Service (POS) plan is an Iowa based network that offers flexibility for you by providing in and out-of-network coverage from local doctors and hospitals. With this said, even though this is an Iowa based network, you do not need to stay in Iowa for care. You can doctor anywhere! Blue Cross & Blue Shield of any state in the U.S. keeps you in network. Claims that fall outside of the Blue Choice POS network will process to your deductible. Your in and out-of-network benefits are the same, due to the partially-self funding. If you are outside of the Blue Choice POS Network, you will only be subject to your deductible and your coinsurance until you meet your out-of-pocket maximum.

REGISTER ONLINE

Your connection to great healthcare is only a click away. Register for an online account at **www.wellmark.com** so you can access time- saving tools, tips for healthy living, view lab results, choose a doctor, manage your EOBs, and more!

DOWNLOAD THE MOBILE APP

With the **Wellmark** mobile app, you've got the tools you need to manage your healthcare all from your smartphone. The mobile app is available in the Apple and Google Play store.

How does our plan work?

Although Wellmark BCBS is the main carrier for our medical insurance, our plans are actually processed by two carriers, Wellmark BCBS and EBS(through the Iowa Governmental Health Care Plan). Hospital based claims are processed by Wellmark first, then automatically forwarded to EBS. It can take 1-2 weeks from the time Wellmark receives the claim for it to be fully processed. Do not pay a hospital bill until you have received your Explanation of Benefits (EOB) from BOTH Wellmark and EBS. Office visits and prescription drug claims are processed by Wellmark only. Your copayment applies at the time of these services. You can refer to page 9 for more details on this process.

MEDICAL PLAN COMPARISON

	$500 POS Plan		$1,000 POS Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (Embedded)				
Individual	$500 (Wellmark Base Plan $5,000)		$1,000 (Wellmark Base Plan $5,000)	
Family	$1,000 (Wellmark Base Plan $10,000)		$2,000 (Wellmark Base Plan $10,000)	
Annual Out-of-Pocket Maximum				
Individual	$1,000 (Wellmark Base Plan $7,350)		$2,000 (Wellmark Base Plan $7,350)	
Family	$2,000 (Wellmark Base Plan $14,700)		$4,000 (Wellmark Base Plan $14,700)	
Lifetime Maximum	Unlimited		Unlimited	
Coinsurance/Copays	**You Pay**		**You Pay**	
Preventive Care	Covered at 100%	Deductible, 40% Coinsurance	Covered at 100%	Deductible, 40% Coinsurance
Office Visit (PCP & Specialist)	$10 Designated PCP $15 Copay Other PCP/Specialist	Deductible, 40% Coinsurance	$10 Designated PCP $15 Copay Other PCP/Specialist	Deductible, 40% Coinsurance
Telehealth (DOD)	Covered at 100%		Covered at 100%	
Urgent Care	$15 Copay	Deductible, 40% Coinsurance	$15 Copay	Deductible, 40% Coinsurance
Emergency Room	Deductible, 20% Coinsurance		Deductible, 20% Coinsurance	
Inpatient Hospital Care	Deductible, 20% Coinsurance	Deductible, 40% Coinsurance	Deductible, 20% Coinsurance	Deductible, 40% Coinsurance
Outpatient Surgery	Office: $15 Copay Facility: Deductible, 20% Coinsurance	Deductible, 40% Coinsurance	Office: $15 Copay Facility: Deductible, 20% Coinsurance	Deductible, 40% Coinsurance
Pharmacy Out-Of-Pocket Max	Single - $1,000 Family - $2,000		Single - $2,000 Family - $4,000	
Prescription Drugs (Retail – 30 Days) **Specialty** [1]	$10 Tier 1 / $25 Tier 2 / $40 Tier 3 & 4 PrudentRx Eligible: $0 Copayment All Others: $85 Copayment		$10 Tier 1 / $25 Tier 2 / $40 Tier 3 & 4 PrudentRx Eligible: $0 Copayment All Others: $85 Copayment	
Prescription Drugs (Mail Order – 90 days)	2 Copays		2 Copays	

[1] Eligible specialty medications not purchased through PrudentRx will be subject to 30% coinsurance. PrudentRx Drug List can be found here Wellmark Drug List.

UNDERSTANDING YOUR RESPONSIBILITY (Embedded Deductible)

Each family member has an individual deductible in addition to the overall family deductible. This means that, if an individual in the family reaches his or her deductible before the family deductible is reached, his or her services will be paid by the insurance company at 100%.

Plan 1 $500 (individual) / $1,000 (family) or
Plan 2 $1,000 (individual) / $2,000 (family)

SPECIALTY PRESCRIPTION DRUG PROGRAM

Collins-Maxwell CSD is implementing PrudentRx effective July 1, 2024 through Wellmark BCBS.

PrudentRx offers a third-party (manufacturer) copay assistance program that may help save you money on your specialty medications.

If you have a chronic condition and take specialty medications on the PrudentRx Drug List you could pay nothing out of pocket!

Enrollment in the program will be started automatically, but you must speak with a PrudentRx advocate to finalize enrollment. If you are currently taking a specialty medication, you will receive a letter in early June; shortly after, PrudentRx will begin their telephonic outreach.

Specialty Program Highlights

	Plan 1	Plan 2
PrudentRx Eligible*	$0 - No Cost	$0 - No Cost
Specialty Medications not on PrudentRx Drug List	All Others: $85 Copayment	All Others: $85 Copayment

*Members that do not fill eligible medications through PrudentRx will be subject to 30% coinsurance which does not count toward out-of-pocket maximum.

UNDERSTANDING HOW YOUR PARTIALLY-SELF FUNDED PLAN WORKS

In-Network Health Claim

Hospital & Physician Services, Office Visits, and Prescription Copays
Deductibles – Coinsurance – Out-of-Pocket Maximums, or Copays

Wellmark Blue Cross & Blue Shield

Doctors Office Visits - $15 Copay – EBS does NOT process
Prescription Drugs - $10/$25/$40/$85 Copay – EBS does NOT process

Wellmark will process the bill to these parameters:
$5,000 Single / $10,000 Family Deductible
$7,350 Single / $14,700 Family Out-of-Pocket Maximum
Member Coinsurance: 30%

You will receive an EOB from Wellmark based on these parameters!

Employee Benefit Systems

Once processed by Wellmark, your claim will be sent electronically to EBS

EBS will reprocess the bill to these parameters:
Plan Option 1 Deductible - $500 Single / $1,000 Family
Plan Option 2 Deductible - $1,000 Single / $2, 000 Family
Plan Option 1 Out-of-Pocket Max - $1,000 Single / $2,000 Family
Plan Option 2 Out-of-Pocket Max - $2,000 Single / $4,000 Family
Member Coinsurance: 20%

Only covered services that apply to deductible and coinsurance are reprocessed
You will receive a second EOB from EBS based on these parameters

Check will then be sent from EBS to your provider
EOB sent to Member

Paid by the Member

Plan 1 - $500 Single / $1,000 Family Deductible
Plan 2 - $1,000 Single / $2,00 Family Deductible
20% Coinsurance
Plan 1 - $1,000 Single / $2,000 Family TOTAL Out-of-Pocket Maximum
Plan 2 - $2,000 Single / $4,000 Family TOTAL Out-of-Pocket Maximum

TIPS ON GETTING THE MOST OUT OF YOUR HEALTH INSURANCE

Understanding the ins and outs of health insurance can be confusing, but it's worth your time to check on benefits you could be losing out on or mistakes that could cost you money. Here are five ways to ensure you're getting the most out of your health insurance:

1

Preventive Care – Our plan covers several preventive services such as annual screenings, flu shots, etc. at no cost! Click HERE for a full list of covered preventive services.

2

Virtual Visits – Wellmark partners with Doctor on Demand so you can access a doctor 24/7, even from the comfort of your home at **NO COST!** Save time by downloading the app today and entering your Wellmark member information.

3

Save on Prescription Drugs – Shopping around for prescription drugs can save you money on copayments. Online apps such as Good Rx and Cost-Plus Drugs make it easy to review your options.
Note: Expenses incurred through these plans will not apply to your out-of-pocket maximum.

4

Tax Savings Accounts – Contributing to an FSA is a great way to set aside pre-tax dollars for healthcare expenses. Browse a list of eligible FSA items at the FSAstore.com.

5

Plan Selection – We understand it's easy to "renew as is" each year but consider exploring both options and their premium cost!

FLEXIBLE SPENDING ACCOUNT (FSA)

Collins-Maxwell CSD allows you to contribute to one or both Flexible Spending Accounts. These FSAs are administered by EBS.

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

How the FSAs Work

Collins-Maxwell CSD offers two types of FSAs:

- Health Care FSA
- Dependent Care FSA

If you elect to contribute to one or both of the FSAs, you choose an annual amount to be taken from each of your paychecks and deposited into your account throughout the year. Your contributions are taken out of your paycheck before you pay taxes, so you save money. Then, when you have eligible health care or dependent care expenses, you can use the account to reimburse yourself, up to the amount you have elected to contribute to your account for the year.

With both accounts, the IRS requires you to use all of the money in your account by the end of the year or you lose it. This is called the "use it or lose it" rule.

Health Care FSA

You can use the Health Care FSA to pay for eligible out-of-pocket expenses that are not covered by another health plan. Examples include, but are not limited to:

- Deductible, coinsurance and copayments
- Prescriptions and certain over the counter medications
- Dental services and orthodontia
- Eyeglasses, contacts, and other vision-related expenses not covered by the vision plan
- Hearing services, including hearing aids and batteries.

Health Care FSA Annual Contribution Amount

You can contribute a maximum of $3,200 per year to the Health Care FSA.

DEPENDENT CARE FSA

The Dependent Care FSA helps you afford day care for your children under age 13 or for a disabled dependent. There are some special rules for participating in this account:

- The day care expenses must be necessary so you can work.
- You can only be reimbursed for expenses incurred during the plan year.
- If you are married, your spouse must be employed, a full-time student at least five months during the plan year, or mentally or physically disabled and unable to provide care for himself or herself.

Dependent Care FSA Annual Contribution Amount

You can contribute a maximum of $5,000 per year to the Dependent Care FSA. If you are married and you and your spouse file separate tax returns, the maximum you can contribute is $2,500.

WHAT'S AN ELIGIBLE EXPENSE?

Health Care FSA – Plan deductibles, copays, coinsurance, and other health care expenses. To learn more, see IRS Publication 502 at www.irs.gov.

Dependent Care FSA – Child day care, babysitters, home care for dependent elders, and related expenses. To learn more, see IRS Publication 503 at www.irs.gov.

DENTAL PLAN

Collins-Maxwell CSD's Dental Plan is administered through Equitable and provides you and your family with coverage for typical dental expenses, such as cleanings, X-rays and fillings.

Dental Plan Highlights

Plan Feature	Equitable Dental Network	Out-of-Network
Annual Deductible Individual Family	$25 $50	
Annual Benefit Maximum	$1,000	
Diagnostic/ Preventive Services (Exams, routine cleanings, fluoride treatments, space maintainers, x-rays)	100%	100%
Basic Services (Posterior, endodontics – root canal therapy)	80%	80%
Major Services (Crowns, inlays, onlays, bridges, dentures)	50%	50%

Search for dental providers at Equitable - Find a dentist.

VISION PLAN

Collins-Maxwell CSD's Vision Plan promotes preventive care through regular eye exams and provides coverage for corrective materials, such as glasses and contact lenses. The Vision Plan is administered through Equitable.

Vision Plan Highlights

The Vision Plan is designed to cover eye care needs that are visually necessary. You have to pay extra if you choose certain cosmetic or elective eyewear, so be sure to ask your eye doctor what items are covered by the plan before you purchase material.

	In-Network VSP	Out-of-Network
Exam Copay	$10	N/A
Prescription Glasses	$25	N/A
Annual Eye Exam	Covered in full after copay	Up to $45
Contact Lens Exam	$60 copay	Included in Lens
Lenses (Single, Bifocal, Trifocal, Lenticular)	Covered in full after copay	Up to $30, $50, $65, $100
Premium Progressive	$55 copay	N/A
Custom Progressive	$95-$175 copay	N/A
Frames	Up to $130	Up to $70
Contacts	Up to $130	Up to $105
Medically Necessary	Covered in full	Up to $210
Benefit Frequency		
Exam	Once every 12 months	
Frames	Once every 24 months	
Lenses	Once every 12 months	
Contacts	Once every 12 months	

Search for vision providers at Equitable - Find a vision professional.

LIFE INSURANCE COVERAGE

Collins-Maxwell CSD offers life insurance coverage to provide financial protection in the event you or your dependents should pass away while you are still working. This coverage is administered through Equitable.

BASIC LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) PLAN

Collins-Maxwell CSD automatically provides Basic Life and Accidental Death and Dismemberment Insurance for all eligible employees at no cost.

Basic Life Insurance is equal to 1 times your annual base earnings, up to a maximum benefit of $150,000. The benefit is paid to your beneficiaries in the event of your death.

SUPPLEMENTAL LIFE AND AD&D INSURANCE

In addition to Basic Life Insurance, you may also purchase Optional Life and AD&D Insurance for yourself, your spouse, and your dependent children. However, you may only elect coverage for your dependents if you enroll for Optional Life coverage for yourself. You pay for the cost of Optional Life Insurance on an after-tax basis through payroll deductions.

For members currently enrolled in the optional life, you can increase your current amount by 2 increments, up to the guaranteed issue amount listed below without having to complete evidence of insurability (EOI). EOI would be needed for any increases above this amount or for anyone newly enrolling.

BENEFICIARY DESIGNATION

You must designate a beneficiary for Basic and Optional Life Insurance benefits when you enroll. Your "beneficiary" is the person(s) who will receive the benefits from your Life and AD&D coverage in the event of your death. You are always the beneficiary of any Dependent Life and AD&D Insurance you elect. You can change your beneficiaries at any time during the year.

If you do not name a beneficiary, or if your beneficiary dies before you, your Life and AD&D benefits will be paid to your estate.

BENEFITS REDUCE AT AGE 65

When you or a covered dependent reaches age 65, Basic and Optional Life Insurance benefits are reduced. For more information, refer to your Group Life Insurance plan document.

Optional Life Insurance Coverage

Coverage For	Coverage Available
Employee	Increments of $10,000 up to $500,000 not to exceed 5x annual salary Guarantee Issue: $100,000
Spouse	Increments of $10,000 up to $250,000 not to exceed 50% of employee amount Guarantee Issue: $30,000
Child(ren)	Increments of $1,000 up to $10,000

INPUTED INCOME

Under current tax laws, imputed income is the value of your Basic Life insurance that exceeds $50,000 and is subject to federal income, Social Security and state income taxes, if applicable. This imputed income amount will be included in your paycheck and shown on your W-2 statement.

DISABILITY COVERAGE

Collins-Maxwell CSD offers you a Long-Term Disability benefit that works to keep all or part of your paycheck coming if you cannot work because of ongoing injury or illness. This benefit is administered through Equitable.

Long-Term Disability

If you remain totally disabled and unable to work for more than 90 days, you may be eligible for Long-Term Disability (LTD) benefits. Collins-Maxwell CSD automatically provides you LTD benefits that replace up to 60% of your base pay, up to a maximum of $5,000 per month. Your monthly LTD benefit will be reduced by Social Security and any other disability income you are eligible to receive (such as Workers' Compensation).

When Are You Disabled?

To be considered totally disabled and eligible for LTD benefits, you must be approved by the insurance carrier and seeing a doctor regularly for treatment. Your doctor must certify that you are not able to perform the material duties of your regular occupation.

ACCIDENT COVERAGE

As a full-time employee, you have the option to enroll in accident insurance through Equitable. This is a voluntary benefit and employees pay the full cost of this coverage. An accident policy supplements your medical coverage and provides a cash benefit for injuries you or a covered family member sustain from an accident. This plan includes coverage for accidents that occur both on and off the job.

BENEFIT OVERVIEW	Employee	Spouse	Children
Accidental Death	$50,000	$50,000	$25,000
Common Carrier	$100,000	$100,000	$50,000
Catastrophic Loss			
Arms, legs, hands, eyes, ears, etc	$15,000	$15,000	$7,500
One arm, hand, leg	$7,500	$7,500	$3,750
Toes, fingers	$750-$1,500	$750-$1,500	$375-$750
Speech, hearing	$7,500	$7,500	$3,750
Dislocations	$100-$6,000	$100-$6,000	$100-$6,000
Fractures	$325-$8,000	$325-$8,000	$325-$8,000
Paralysis	$1,000-$50,000	$1,000-$50,000	$1,000-$50,000
Lacerations	$65-$500	$65-$500	$65-$500
Burns	$400-$20,000	$400-$20,000	$400-$20,000
MEDICAL SERVICES	**Employee**	**Spouse**	**Children**
Diagnostic Exam-1/year	$200	$200	$200
Related Services	$25-$1,500	$25-$1,500	$25-$1,500
Hospital Admission	$1,500	$1,500	$1,500
Related Services	$100-$4,000	$100-$4,000	$100-$4,000
Emergency Dental-Extraction	$65	$65	$65
Emergency Dental-Crown	$200	$200	$200
Wellness Benefit	$50	$50	$50

*Refer to plan document for full details.

HOW DO I ENROLL?

1. LOG IN

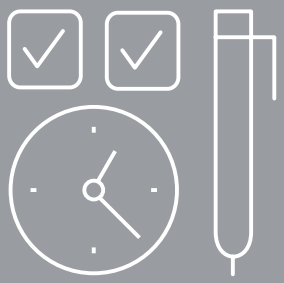
Log into Collins-Maxwell at collins-maxwell.ease.com.

2. CHOOSE YOUR PLAN

Utilize Ease to help choose the lowest-cost, best-value health plan based on your medical needs.

3. ENROLL

Based off of the best value plan for your needs, enroll in your benefits.



REMINDER

Benefits enrollment must be completed within 31 days of your event.

Make sure you hit 'submit' to save your elections before closing the window.

IMPORTANT CONTACTS

Resource	Carrier/Vendor	Phone Number	Website
Medical	Wellmark	800-524-9242	www.wellmark.com
Voluntary Dental **Voluntary Vision** **Flexible Spending Accounts (FSA)** **Basic Life/A&D, Supp Life/AD&D, LTD** **Accident**	Equitable	866-274-9887	www.equitable.com
Holmes Murphy Contacts	Brenna Williams	515-223-7048	bwilliams@holmesmurphy.com
	Sara Bradshaw	515-223-6940	sbradshaw@holmesmurphy.com
	Hannah Schuster	402-697-4713	hschuster@holmesmurphy.com

BENEFITS DEFINITIONS

COINSURANCE

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)

COPAYMENT

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service (sometimes called "copay"). The amount can vary by the type of covered health care service.

DEDUCTIBLE

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered health care services subject to the deductible.)

OUT-OF-POCKET MAXIMUM

The most you could pay during a coverage period (calendar year) for your share of the costs of covered services. After you meet this limit the plan will pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

NETWORK

The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

NETWORK PROVIDER

A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

OUT-OF-NETWORK PROVIDER

A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non- participating" instead of "out-of-network provider."

BENEFITS DEFINITIONS (CONT.)

PREMIUM

The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

PROVIDER

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

REFERRAL

A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

HIGH-DEDUCTIBLE HEALTH PLAN (HDHP)

A type of health plan that has lower monthly premiums, but higher deductibles and out-of- pocket limits, than a traditional health plan.
HDHPs are often coupled with an HSA (Health Savings Account) – Collins-Maxwell CSD does not have a HDHP.

Required Notices

IMPORTANT NOTICE FROM COLLINS-MAXWELL CSD ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

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

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Collins-Maxwell CSD coverage will not be affected.
If you do decide to join a Medicare drug plan and drop your current Collins-Maxwell CSD coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Collins-Maxwell CSD and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.
If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Collins-Maxwell CSD changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	2024 Plan Year
Name of Entity/Sender:	Collins-Maxwell CSD
Contact--Position/Office:	Traci Nessa – School Business Official
Address:	400 Metcalf Maxwell, IA 50161
Phone Number:	515-387-1115

HIPAA SPECIAL ENROLLMENT NOTICE

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

Loss of Other Coverage (including Medicaid and State Child Health Coverage)

If you are declining coverage for yourself or your dependents (including spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). Some plans may allow longer than 30 days, so please refer to your plan documents for your specific plan details.

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

Marriage, Birth, or Adoption

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 dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption. Some plans may allow longer than 30 days, so please refer to your plan documents for your specific plan details.

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

Medicaid or State Child Health Coverage

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

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

WOMEN'S HEALTH & CANCER RIGHTS ACT OF 1998

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications at all stages of the mastectomy, including lymph edemas.

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under this plan.

NEWBORNS' AND MOTHER'S HEALTH PROTECTION ACT

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).

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Beginning in 2014, there is a new way to buy health insurance: the **Health Insurance Marketplace**. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Each year, the open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the previous year. After Dec. 15, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent (as adjusted each year after 2014) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (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.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Business Office. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PATIENT PROTECTION NOTICE

Wellmark Blue Cross & Blue Shield requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Wellmark Customer Service at 800-524-9242.

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

You do not need prior authorization from Wellmark Blue Cross & Blue Shield or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Wellmark Customer Service.

PRIVACY NOTICE

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

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

Get a copy of health and claims records
You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.

We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records
You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.

We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

We will consider all reasonable requests and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share
You can ask us not to use or share certain health information for treatment, payment, or our operations.

We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information
You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

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

Choose someone to act for you
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
You can complain if you feel we have violated your rights by contacting us using the information on page 1.

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

We will not retaliate against you for filing a complaint.

YOUR CHOICES

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

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

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases, we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

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

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan, so we can arrange additional services.

Run our organization
We can use and disclose your information to run our organization and contact you when necessary.

We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.
Example: We use health information about you to develop better services for you.

Pay for your health services
We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

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

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
We can share health information about you with organ procurement organizations.

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information.

We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

We must follow the duties and privacy practices described in this notice and give you a copy of it.

We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

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

Other Instructions for Notice

- July 1, 2024

COLLINS-MAXWELL

ELEMENTARY SCHOOL