



2026 Benefits Guide

ANNUAL ENROLLMENT: April 6-17, 2026



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.

Welcome to Your 2026 Benefits Guide

Use this Benefits Guide to see what's new and to learn about your benefit plan options.

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Disclaimer: This benefit summary describes the benefit plans available to you as an employee of Norwalk Community School District. The details of these plans are contained in the official plan documents that have been provided to you by your employer, including some insurance contracts. 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 Norwalk Community School District.

Getting Started!

How Do I Enroll?

Open Enrollment will run from **April 6, 2026 through April 17, 2026**. During this time, you can make changes to your current benefits and add/drop dependents. Otherwise, you must experience a Qualifying Life Event (QLE) to make changes to your benefits midyear.

1. CHOOSE YOUR PLAN

Employees will be emailed a PDF fillable form for health, dental, and vision benefits to complete on the computer. All form(s) can be printed and completed by hand. Employees wishing to make changes to voluntary life benefits should reach out to Rebecca.

Utilize your benefits booklet to help choose the best value health plan based on your medical needs.

2. ENROLL

Enroll in the benefits that will best meet your needs.

Please scan and email signed form(s) to Rebecca Campbell at rebecca.campbell@norwalkschools.org OR send interoffice mail to District Office to the attention of Rebecca Campbell.

REMINDERS: Passive Enrollment

- Open Enrollment is a passive enrollment, meaning your current benefit elections will roll over unless you wish to make changes. All changes must be made during the stated open enrollment period. All benefit changes will be effective July 1st and will remain in effect until 6/30/2027, unless you experience a Qualifying Life Event (QLE). Benefits enrollment must be completed within 30 days of your event.
- If you are enrolled in the PPO 1000 or HMO 1000, you will automatically be mapped to the POS 1000 unless you make a new election.
- For security purposes, please do not include SSN on any enrollment forms as we already have this on file for all employees.
- If you are adding dependents, Rebecca will contact you directly for SSNs.



Eligibility

You and your eligible family members may participate in the 2026-2027 employee benefits program if you're a regular, full-time employee working a minimum of 30 hours per week or benefits eligible as defined by the Employee Handbook.

COVERING YOUR DEPENDENTS

You can enroll the following dependents in our group benefit plans:

- Your legal spouse
- Children up to age 26* for medical coverage; your unmarried, eligible children up to age 25 for dental and vision coverage
- 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

Please refer to your new hire documents to determine when your initial benefit eligibility will take effect.

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

QUALIFYING LIFE EVENTS

Your benefit elections made during Open Enrollment will be effective July 1, 2026. 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.



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.



Contact Rebecca Campbell at Rebecca.Campbell@norwalkschools.org to process a Qualifying Life Event.

Choose Your Medical Plan

Your medical plans will be offered through Wellmark Blue Cross Blue Shield. Please review your summary of Benefits and Coverage (SBC) for additional coverage information and full plan details.

Elections you make during Open Enrollment will be effective July 1, 2026, and remain in effect until June 30, 2027, unless you experience a qualifying life event.

You may visit any medical provider you choose, but in-network providers offer the highest level of benefits and lower out-of-pocket costs. In-network providers charge members reduced, contracted rates instead of their typical fees. Providers outside the plan's network set their own rates, so you may be responsible for the difference if a provider's fees are above the Reasonable and Customary (R&C) limits.



Understanding Your Plan Options

\$1,000 POS: \$1,000 (individual) / \$2,000 (family) & \$1,500 PPO: \$1,500 (individual) / \$3,000 (family) —

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.

\$3,000 HDHP: \$3,000 (individual) / \$6,000 (family) — All family members' out-of-pocket expenses count toward the family deductible until it is met. It doesn't matter if one person incurs all the expenses that meet the deductible or if two or more family members contribute toward meeting the family deductible.



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.



Understanding Your Network Options

Point of Service- POS

- The POS requires you to designate a primary care provider (PCP) from a list of doctors credentialed by Wellmark Health Plan of Iowa, Inc. The primary care provider you select will provide or coordinate your care, and you will have a lesser copayment when you see your primary care provider.
- The in-network coverage includes providers inside the Wellmark Health Plan of Iowa network. You do have coverage for PPO providers outside of the state, but it will be subject to out-of-network coverage levels. You are protected from balance billing when you see a PPO provider.

Find a Provider:

For a complete listing of providers, visit www.wellmark.com, and click on the Member Resources and select “Find a Provider”. If you are looking for a provider, you can select by your network: “Wellmark Blue POS or Wellmark Blue PPO”. Then, enter the desired search criteria.

To search for providers, visit Wellmark’s search tool by clicking [HERE](#).

Preferred Provider Organization- PPO

- You can see any provider you choose, however, if you see a provider who participates in the PPO network, you will have lower out-of-pocket expenses, and claims will be filed for you.

*NOTE: Members enrolled in the POS plan are required to designate a Primary Care Physician (PCP) for their Preventive Care services.

Coordination of care for non-Preventive Care Services through the PCP is recommended, but not required. Contact Wellmark to update your PCP, or login to your MyWellmark portal.



Medical Plans at a Glance

The medical plans shown below are administered through Wellmark Blue Cross Blue Shield. This page compares in-network benefits between plans. Please review your Summary of Benefits and Coverage (SBC) for additional coverage information and full plan details.

	POS \$1,000	PPO \$1,500	PPO HDHP \$3,000
BENEFITS IN-NETWORK			
ANNUAL DEDUCTIBLE			
Individual	\$1,000	\$1,500	\$3,000
Family	\$2,000	\$3,000	\$6,000
OUT-OF-POCKET (OOP) MAXIMUM			
Individual	\$2,000	\$3,000	\$3,000
Family	\$4,000	\$6,000	\$6,000
COINSURANCE			
	You Pay	You Pay	You Pay
Virtual Visits	\$10 Copay	10% Coinsurance	Deductible
Preventive Care	Covered at 100%	Covered at 100%	Covered at 100%
Primary Care Physician (PCP)	\$10 copay	10% Coinsurance	Deductible
Non-Primary Care Office Visit	\$20 copay	10% Coinsurance	Deductible
Specialist	\$20 copay	10% Coinsurance	Deductible
Emergency Room	Deductible, 10% Coinsurance	Deductible, 10% Coinsurance	Deductible
Inpatient Hospital	Deductible, 10% Coinsurance	Deductible, 10% Coinsurance	Deductible
Outpatient Hospital	Deductible, 10% Coinsurance	Deductible, 10% Coinsurance	Deductible
Urgent Care	\$10 Copay	10% Coinsurance	Deductible
Outpatient Surgery	Deductible, 10% Coinsurance	Deductible, 10% Coinsurance	Deductible
BENEFITS OUT-OF-NETWORK			
Deductible	\$1,000 Individual / \$2,000 Family	\$1,500 Individual / \$3,000 Family	\$3,000 Individual / \$6,000 Family
Coinsurance	20%	20%	0%
Out-of-Pocket (OOP) Maximum	\$2,000 Individual / \$4,000 Family	\$3,000 Individual / \$6,000 Family	\$3,000 Individual / \$6,000 Family

*Out-of-network benefits are available for all plans. Refer to full benefit summary for out-of-network benefits. Please note: If you go to an out-of-network provider, your cost may be higher, and your provider may ask you to pay the actual charge for your care at the time of your visit.

Pharmacy- CVS

PRESCRIPTION DRUG PLAN HIGHLIGHTS					
COVERAGE LEVEL		POS \$1,000	PPO \$1,500	PPO HDHP \$3,000	
Deductible (Rx)		Combined with Medical	Combined with Medical	Combined with Medical	
Out of Pocket (OOP) Maximum (Rx)		\$1,500 Individual / \$3,000 Family (3)	Combined with Medical	Combined with Medical	
		You Pay	You Pay	You Pay	
Retail 30-day supply	Tier 1	\$10 Copay	Deductible, 10% Coinsurance	Deductible, 20% Coinsurance	
	Tier 2	\$25 Copay	Deductible, 10% Coinsurance	Deductible, 20% Coinsurance	
	Tier 3	\$40 Copay	Deductible, 10% Coinsurance	Deductible, 20% Coinsurance	
	Specialty	BioSimilar: \$50 Copay Preferred: \$85 Copay Non-preferred: \$100 Copay	Deductible, 10% Coinsurance	Deductible, 20% Coinsurance	
Mail Order 90-day supply	Tier 1	\$20 Copay	Deductible, 10% Coinsurance	Deductible, 20% Coinsurance	
	Tier 2	\$50 Copay	Deductible, 10% Coinsurance	Deductible, 20% Coinsurance	
	Tier 3	\$80 Copay	Deductible, 10% Coinsurance	Deductible, 20% Coinsurance	

1. Drugs listed on Wellmark's Blue Rx Value Plus Drug List are covered. You pay the discounted cost of your prescription drugs until your overall deductible is met.
2. Specialty drugs are covered only when obtained through the CVS Specialty Pharmacy Program.
3. The In-Network Medical and Rx out-of-pocket maximum amounts accumulate separately.



Please visit wellmark.com/prescriptions for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your plan.

If you have a chronic condition and take specialty medications, you must purchase these through a designated specialty pharmacy that provides the pricing and additional support (2). If you have a prescription that meets this requirement, Wellmark BCBS will contact you and provide you with the necessary information to fill your prescription.

Telehealth Benefits

With telehealth, you can schedule a virtual appointment with board-certified doctors and pediatricians who can diagnose, treat and prescribe most medications for minor medical conditions, such as:

- | | | |
|--|--|--|
| <ul style="list-style-type: none">• Acne• Allergies• Asthma• Bronchitis• Cold and flu• Constipation | <ul style="list-style-type: none">• Diarrhea• Insect Bites• Joint aches• Nausea• Pink eye• Rashes | <ul style="list-style-type: none">• Respiratory Infections• Shingles• Sinus infections• Skin Infections• Sore throats• Urinary tract infections |
|--|--|--|

We've all been there—it's the middle of the night and you have a sick child or maybe you are trying to get an appointment with your primary care provider, but the first appointment isn't for two weeks. Good news... there's an easier way! Telehealth is a convenient option for scheduling virtual doctor visits from your own home. With telehealth, you don't have to drive to the doctor's office or sit in a waiting room when you're sick—you can see your doctor from the comfort of your own bed or sofa.

- See a board-certified, licensed, telehealth trained doctor on your schedule with on-demand virtual visits 24/7, including holidays.
- Get treated for more than 80 common conditions including colds, flu, allergies and more.
- Get a prescription or short-term refill of any existing prescription sent to a pharmacy nearby, in less time than your usual doctor visit
- Avoid costly copays and deductibles of the ER and urgent care clinic.



Getting started is easy!

- Download the “Doctor On Demand” app or visit [DoctorOnDemand.com](https://www.doctorondemand.com).
- Have your Wellmark BCBS member ID card ready.
- Create an account or sign in.
- Call 800-997-6196 with any questions 24/7.

Health Savings Account (HSA)

A Health Savings Account (HSA) is a way for you to save pretax dollars that can be used to pay for qualified healthcare expenses like deductibles, copays, co-insurance, prescriptions, vision and dental expenses. You can set up an HSA through Health Equity, our HSA vendor, and make contributions to your account from your paychecks throughout the year.

High deductible health plans have lower premiums and may result in lower annual medical costs. These plans offer several advantages to reward you for taking an active role in your healthcare spending.

- Lower paycheck costs — allowing you to keep control over more of your money
- Tax-advantaged savings account — enrolling in and contributing to a Health Savings Account (HSA) helps you pay your deductible and out-of-pocket costs
- Comparable benefits — these plans use the same networks that other plans offer, and in-network preventive care is still 100% covered

WHO IS ELIGIBLE FOR AN HSA?

- Must be enrolled in a high deductible health plan
- Cannot be covered by any other medical plan that is not a qualified HDHP. This includes a spouse's medical coverage unless it's also a qualified HDHP
- Cannot be enrolled in a traditional health care FSA
- Cannot be enrolled in Medicare, including Parts A or B, Medicaid or Tricare
- Cannot be claimed as a dependent on another person's tax return
- Cannot be a veteran who has received treatment, other than preventive care, through the Department of Veterans Affairs within the past three months

HOW MUCH CAN I CONTRIBUTE TO AN HSA?

When you enroll in the HDHP and set up an HSA, Norwalk Community School District will also contribute to the account for you. The board's contribution will come out to \$175 per month.

Here's a look at what you and Norwalk CSD together can contribute to your HSA each year:

COVERAGE LEVEL	NORWALK CSD ANNUAL CONTRIBUTION	TOTAL HSA CONTRIBUTION ALLOWED FOR 2026
Employee Only	\$2,100	\$4,400
Employee + Spouse	\$2,100	\$8,750
Employee + Child(ren)	\$2,100	\$8,750
Employee + Family	\$2,100	\$8,750

Note: If you are 55 or older, you can make an additional annual catch-up contribution of \$1,000

HSAs AND YOUR TAXES

All withdrawals from your HSA are tax-free, as long as you use the money to pay for eligible health care expenses. In addition, all the money in the account is yours and will never be forfeited. It rolls over from year to year, and you can take it with you if you leave the company or retire. After age 65, you can withdraw funds for any reason without a tax penalty — you pay ordinary income tax only if the withdrawal isn't for eligible health care expenses.

For a list of eligible expenses, see IRS Publication 502, available at www.irs.gov.

Flexible Spending Accounts (FSAs)

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

***FSA OPEN ENROLLMENT IS HELD ANNUALLY IN NOVEMBER**

HEALTH CARE FSA

- Pay for eligible health care expenses, such as plan deductibles, copays, and coinsurance.
- Contribute up to \$3,400 in 2026.

LIMITED PURPOSE FSA

Who can participate?

Employees enrolled in the high-deductible health plan.

What are the contribution limits?

Employees can contribute up to \$3,400 for 2026. You can use the funds for any qualified dental or vision expenses.

No medical plan co-pays, deductibles, prescription drugs or alternative healthcare are eligible expenses through a LP-HFSA

The money allocated to your HCFSA / LP-HFSA will come directly from your paycheck on a pre-tax basis. You can access your funds through a debit card and use this card to pay for copayments, doctor's visits, prescription drugs, and eligible over-the-counter medications.

What happens at the end of the year?

You will be able to carryover (or rollover) up to \$680 of unused funds from your 2026 election into the 2026 plan year. Any unused amount over \$680, you will lose.

DEPENDENT CARE FSA

Who can participate?

Any employee.

What are the contribution limits?

Employees can contribute up to \$7,500 annually per family or \$3,750 if filing separately.

What happens at the end of the year?

FSA funds expire at the end of each year. Unlike the healthcare FSA, your full election for the plan year is not available on the day your plan starts. For the dependent care FSA, you can only be reimbursed for qualified expenses up to the amount you have contributed to your FSA up to that point in time. As your contributions accrue, claims for reimbursement can be processed.

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.



HSA & FSA Comparison

This chart shows the features of the healthcare FSAs and the Health Savings Account (HSA) and compares the Limited Purpose Health Care FSA to the traditional Health Care FSA.

	HSA	LIMITED PURPOSE HEALTH CARE FSA*	PPO, POS, OR NO MEDICAL PLAN ENROLLMENT
Available if you select these plans	High-deductible Health Plan	High-deductible Health Plan	PPO, POS, or No Medical Plan Enrollment
How much you may contribute	\$4,400 (EE only) \$8,750 (all other coverage levels) Catch-up contributions of up to \$1,000 for 2026 year for age 55+	Up to \$3,400 for plan year	
Expenses you may pay from your account	Out-of-pocket Medical Prescription drug Dental Vision Long-Term Care premium	Out of pocket expenses incurred during the current calendar year (including the grace period):	
		Dental Vision	Medical Prescription drugs Dental Vision
Account balance available to reimburse expenses	Current account balance	Entire contribution amount elected for the plan year	
Time limits for using your account balance	No limit	Must use 2026 account balance for expenses incurred through December 31st Claims must be filed by March 31st	
If you don't use all your account balance each year	Any account balance carries over from year-to-year	Any remaining funds above \$680 will be forfeited	
How it saves you money	Your contributions are tax free, which reduces your taxable income Any investment or interest earnings on your account balance is tax free Distributions are tax free if used for qualified healthcare expenses	Your contributions are tax-free, which reduces your taxable income and increases your take-home pay You pay for healthcare expenses with pre-tax dollars	

Dental Plan

In addition to protecting your smile, dental insurance helps pay for dental care and includes regular checkups, cleanings and x-rays. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery. Dental coverage is offered for basic and major services. The dental plan also includes 100% coverage for preventive care. You and your eligible dependents may enroll in one of the two dental coverage options administered by Delta Dental of Iowa.

PPO & PREMIER NETWORKS

The Dental PPO allows you the freedom to visit any dentist, without referrals, for all your dental care. If you receive care from one of Delta Dental’s network dentists, you’ll pay less for your care. If you choose a non-network dentist, your share of costs will generally be higher, and you may need to file your own claims.

Rollover: Any unused annual benefit maximums (\$1,250 Low Plan & \$1,750 High Plan) will rollover each year. To take advantage, you will need to incur the annual deductible each year. You may not have an annual maximum balance of more than 2x the annual maximum. Rollover amounts that exceed that are forfeited.

IN-NETWORK- (PPO) PLAN FEATURES	DENTAL – LOW PLAN	DENTAL – HIGH PLAN
Annual Deductible – Individual	\$25	\$25
Annual Deductible – Family	\$75	\$75
Annual Maximum	Calendar Year: \$1,250	Calendar Year: \$1,750
Preventive Care	Deductible Waived; covered at 100%	Deductible Waived; covered at 100%
	You Pay	You Pay
Basic Services	10% after deductible	10% after deductible
Major Services	20% after deductible	20% after deductible
Cast Restorations & Prosthetics	50% after deductible	50% after deductible
Orthodontia Services* Adults & Children under age 26	N/A	50% coinsurance up to Lifetime Maximum of \$1,500



To search for providers, scan below.



Vision Plan

Driving to work, reading a news article and watching TV are all activities you likely perform every day. Your ability to do all of these activities, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems.

Your vision insurance is provided by National Insurance Services and entitles you to specific eye care benefits. Please note this benefit will renew on September 1, whereas all other benefits will renew on July 1. Our policy covers routine eye exams and other procedures, and provides specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses.

Extra Savings Offered:

- Discounted laser vision corrective treatment at contracted facilities
- Discounts on additional glasses and sunglasses
- \$39 copay for routine retinal screening



	IN-NETWORK	OUT-OF-NETWORK
Vision Exam – Premier Locations	\$0 Copay	Reimbursed up to \$45
Vision Exam – All Other Locations	\$10 Copay	
Materials Copay	\$25 Copay	
EYEGLOSS LENSES MATERIALS & FRAMES		
Single Vision Lenses	Paid in Full after Materials Copay	Reimbursed up to \$30
Standard Lined Bifocal Lenses	Paid in Full after Materials Copay	Reimbursed up to \$50
Standard Trifocal Lenses	Paid in Full after Materials Copay	Reimbursed up to \$65
Frames	\$180 Wholesale Allowance \$230 Allowance for Featured Brands	Reimbursed up to \$70
Elective Contact Lenses (in lieu of spectacle lenses)	\$180 Allowance	Reimbursed up to \$105
Contact Lens Fitting/Evaluation	Up to \$60	N/A
FREQUENCY OF SERVICES		
Comprehensive Eye Exam	Once Every 12 Months	Once Every 12 Months
Lenses	Once Every 12 Months	Once Every 12 Months
Frames	Once Every 24 Months	Once Every 12 Months
Contact Lenses	Once Every 12 Months	Once Every 12 Months

To find a network provider, click [HERE](#).

Employee Assistance Program

We understand that we all face serious problems at some time in our lives and Norwalk Community School District is committed to providing help during those times.

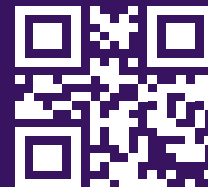
The LifeWorks EAP is designed to assist staff members and families with personal challenges in many different areas, including depression, stress management, drug and alcohol abuse, relationships, grief, domestic violence, legal and financial issues, parenting, childcare and elder care.

Participation in the EAP is voluntary, confidential and free of cost for the first 3 visits. For those who require referrals for long-term treatment, there may be fees for the services of outside providers. However, EAP counselors will coordinate referrals, whenever possible, to take advantage of existing insurance coverage and community resources in order to minimize costs

Through the EAP employees can also access NIS's Claimant Assist, which offers special services to long-term disability claimants or life insurance beneficiaries at no charge. We encourage you and your eligible family members to take advantage of our EAP benefit and to reach out to National Insurance Services.



Phone: 866.451.5464
Online: Claimant Assist Services
Are Available: 866.472.2734
or scan the QR code below!
Login: NISEAP / Password: EAP



Virtual Fitness

Employees also have access to a virtual fitness platform through the EAP. **LIFT session**, one of the leading fitness providers, provides you with an easily accessible, effective and affordable way to reach your fitness goals anytime, anywhere for better health and well-being. You can work out on your own with personalized programs and access coaches if you have questions or choose to work under the live supervision of a coach online, in 1-1 personal or group sessions.



Employer-Paid Benefits

These benefits are automatically provided when you become newly eligible (such as your hire date or a qualifying life event). **They are not available to elect or change during Open Enrollment**, but are included here to help you understand the full range of coverage provided by Norwalk CSD.

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

The Basic Life and AD&D plan provides a benefit in the event of your death, dismemberment or paralysis. This benefit is sponsored by **Norwalk Community School District**, so you will automatically be enrolled at no cost to you.

- Teachers & 12-month Classified Employees: \$25,000

You must designate a beneficiary for Basic Life and AD&D 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 passing. You can change your beneficiaries at any time during the year.

LONG-TERM DISABILITY (LTD)

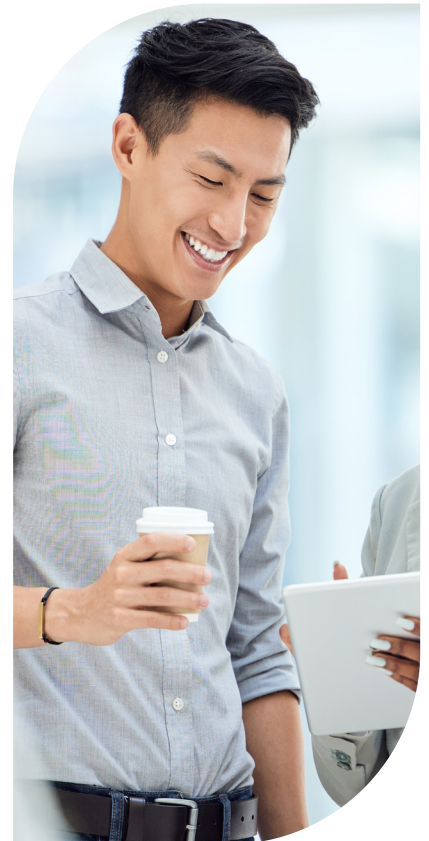
At **Norwalk Community School District**, we want to do everything we can to protect you and your family. That’s why **Norwalk Community School District** pays for the full cost of short and long-term disability insurance—meaning that you owe nothing out of pocket. These benefits are administered through National Insurance Services

In the event that you become disabled from a non- work related injury or sickness,

disability income benefits will provide a partial replacement of lost income.

If you are disabled and unable to work for 90 days or longer, you may be eligible for long-term disability. The benefit is 60% of your total covered earnings, up to a maximum of \$11,750 per month.

This benefit continues until you recover or reach your Social Security normal retirement age, whichever is sooner.



Voluntary Benefits

VOLUNTARY LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

You may purchase additional life insurance at group rates:

- Available in increments of **\$10,000**, up to **\$300,000** or 5 times your salary
- You pay the full cost of this plan and the amount deducted depends on the age of the associate and the amount of coverage elected
- If you do not elect this coverage when first becoming eligible or an election over **\$150,000** is made, you are subject to medical underwriting by the carrier

SPOUSAL AND CHILD LIFE INSURANCE

You may purchase additional dependent life insurance at group rates:

- Spousal life is available in increments of **\$5,000**, up to a max of **\$150,000**, not to exceed 50% of the employee benefit amount elected
- Can elect up to **\$25,000** without medical underwriting as a new hire
- Child life is available as a flat **\$5,000** or **\$10,000** benefit

Age Benefit Reductions

Please note that Benefit Reductions based on age would apply as follows:

- Reduces to 65% at age 65
- Reduces to 50% at age 70
- Terminates at Retirement

Guaranteed Issue & Evidence of Insurability

Employees and spouses who elect Voluntary Life and AD&D coverage when they are first eligible can elect up to the Guaranteed Issue (GI) amount without Evidence of Insurability (EOI). If the amount requested is more than GI, you will need to provide EOI before the amount over GI becomes effective. Please note that once you or your spouse reaches age 70+, the Guaranteed Issue amount no longer applies.

To learn more, please refer to your benefit summary or call National Insurance Services at 262-780-1252.



Identity Theft Assistance

There is an identity theft victim every two seconds. If you are a victim, the IDX Identity Theft Recovery specialists will provide concierge-style service every step of the way. Their expertise will offer peace of mind and save valuable time during this stressful process. Resolution services are offered to you by Norwalk CSD & Madison National Life.

Your dedicated recovery specialist will work with you until the identity is restored to pre-fraud status. For more information, call (855) 205-6010.

Support may include:

- Assistance with investigation of the suspected identity theft
- Guidance through the recovery process
- Recovery for all 9 types of identity theft
- Advice from trained professionals in identity protection
- Single point-of-contact if you are a victim
- Assistance with notifying law enforcement or local government agencies
- Limited Power of Attorney to work on the victim's behalf
- Documentation including fraud affidavit
- And much more



GRANDFATHERED STAFF- Monthly Insurance Premiums

Certified Staff hired before 7/1/2016 and Current Grandfathered 9- and 12-month staff

HDHP 3000			
	Employee	EMPLOYER	TOTAL COST
Employee Only	\$0.00	\$775.00	\$775.00
Employee + Spouse	\$275.00	\$1,325.00	\$1,600.00
Employee + Child(ren)	\$150.00	\$1,325.00	\$1,475.00
Family	\$645.00	\$1,725.00	\$2,370.00
HSA		\$175.00	
POS 1000			
	EMPLOYEE	EMPLOYER	TOTAL COST
Employee Only	\$0.00	\$810.00	\$772.28
Employee + Spouse	\$335.00	\$1,325.00	\$1,581.63
Employee + Child(ren)	\$205.00	\$1,325.00	\$1,261.91
Family	\$735.00	\$1,725.00	\$2,370.14
PPO 1500			
COVERAGE LEVEL	EMPLOYEE	EMPLOYER	TOTAL COST
Employee Only	\$70.00	\$810.00	\$880.00
Employee + Spouse	\$455.00	\$1,325.00	\$1,780.00
Employee + Child(ren)	\$320.00	\$1,325.00	\$1,645.00
Family	\$950.00	\$1,725.00	\$2,675.00

ALL OTHER STAFF- Monthly Insurance Premiums

Administration, Classified, Professional & Confidential

HDHP 3000 (9, 10 or 12 MONTH)			
	Employee	Employer	Total Cost
Employee Only	\$0.00	\$775.00	\$775.00
Employee + Spouse	\$825.00	\$775.00	\$1,600.00
Employee + Child(ren)	\$700.00	\$775.00	\$1,475.00
Family	\$920.00	\$1,450.00	\$2,370.00
HSA		\$175.00	
POS 1000 (9, 10 or 12 MONTH)			
	Employee	Employer	Total Cost
Employee Only	\$0.00	\$810.00	\$810.00
Employee + Spouse	\$850.00	\$810.00	\$1,660.00
Employee + Child(ren)	\$720.00	\$810.00	\$1,530.00
Family	\$1,010.00	\$1,450.00	\$2,460.00
PPO 1500 (9, 10 or 12 MONTH)			
COVERAGE LEVEL	Employee	Employer	Total Cost
Employee Only	\$70.00	\$810.00	\$880.00
Employee + Spouse	\$970.00	\$810.00	\$1,780.00
Employee + Child(ren)	\$835.00	\$810.00	\$1,645.00
Family	\$1,225.00	\$1,450.00	\$2,675.00

Dental & Vision Rates

CERTIFIED 2026-2027 - DENTAL			
LOW PLAN			
	<u>Employee</u>	<u>Employer</u>	<u>Total Cost</u>
Single	\$38.12	\$0.00	\$38.12
EE/SP	\$75.30	\$0.00	\$75.30
EE/CH	\$83.14	\$0.00	\$83.14
Family	\$139.70	\$0.00	\$139.70
HIGH PLAN			
	<u>Employee</u>	<u>Employer</u>	<u>Total Cost</u>
Single	\$41.40	\$0.00	\$41.40
EE/SP	\$81.82	\$0.00	\$81.82
EE/CH	\$103.00	\$0.00	\$103.00
Family	\$169.42	\$0.00	\$169.42

CLASSIFIED, PROFESSIONAL, CONFIDENTIAL 2026-2027 - DENTAL			
LOW PLAN			
	<u>Employee</u>	<u>Employer</u>	<u>Total Cost</u>
Single	\$28.12	\$10.00	\$38.12
EE/SP	\$65.30	\$10.00	\$75.30
EE/CH	\$73.14	\$10.00	\$83.14
Family	\$129.70	\$10.00	\$139.70
HIGH PLAN			
	<u>Employee</u>	<u>Employer</u>	<u>Total Cost</u>
Single	\$31.40	\$10.00	\$41.40
EE/SP	\$71.82	\$10.00	\$81.82
EE/CH	\$93.00	\$10.00	\$103.00
Family	\$159.42	\$10.00	\$169.42

ADMINISTRATION 2026-2027 - DENTAL			
LOW PLAN			
	<u>Employee</u>	<u>Employer</u>	<u>Total Cost</u>
Single	\$0.76	\$37.36	\$38.12
EE/SP	\$37.94	\$37.36	\$75.30
EE/CH	\$45.78	\$37.36	\$83.14
Family	\$102.34	\$37.36	\$139.70
HIGH PLAN			
	<u>Employee</u>	<u>Employer</u>	<u>Total Cost</u>
Single	\$0.83	\$40.57	\$41.40
EE/SP	\$41.25	\$40.57	\$81.82
EE/CH	\$62.43	\$40.57	\$103.00
Family	\$128.85	\$40.57	\$169.42

ALL EMPLOYEES - VISION			
LOW PLAN			
	<u>Employee</u>	<u>Employer</u>	<u>Total Cost</u>
Single	\$9.22	\$0.00	\$9.22
EE/SP	\$18.48	\$0.00	\$18.48
EE/CH	\$19.75	\$0.00	\$19.75
Family	\$31.60	\$0.00	\$30.16

Important Contacts

PLAN	CARRIER	WEBSITE	PHONE
Medical & Pharmacy	Wellmark Blue Cross Blue Shield	https://www.wellmark.com/	800-524-9242
Dental	Delta Dental of Iowa	https://www.deltadentalia.com/	800-544-0718
Vision	VSP	www.vsp.com	800-877-7195
Health Savings Account (HSA) & Flexible Spending Accounts (FSAs)	HealthEquity	www.healthequity.com	866-346-5800
Life / AD&D / Disability Employee Assistance Program	National Insurance Services (NIS)	eebay@nisbenefits.com	Erin Eby: 262-780-1252
Benefits Specialist -Norwalk	Rebecca Campbell	Rebecca.Campbell@norwalkschools.org	515-981-0676, Ext. 4002
Holmes Murphy	Emily Patterson	Epatterson@holmesmurphy.com	515-974-4634
	Alesha Wilhite	AWilhite@holmesmurphy.com	515-518-2360

Legal Notices

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

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

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12% of your annual household income, or if the coverage through your employment does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee’s cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee’s household income.

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

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15. Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you’ve had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan. There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children’s Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is **offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility.

To learn more, visit [HealthCare.gov](https://www.healthcare.gov) or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

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

1. Indexed annually; see irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
2. An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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

Special Enrollment Notice

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

LOSS OF OTHER COVERAGE

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

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

MARRIAGE, BIRTH OR ADOPTION

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

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

MEDICAID OR CHIP

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

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

FOR MORE INFORMATION OR ASSISTANCE

To request special enrollment or obtain more information, please contact Human Resources.

Your Information. Your Rights. Our Responsibilities.

This notice describes:

- HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
 - YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION
 - HOW TO FILE A COMPLAINT CONCERNING A VIOLATION OF THE PRIVACY OR SECURITY OF YOUR HEALTH INFORMATION, OR OF YOUR RIGHTS CONCERNING YOUR INFORMATION
- YOU HAVE A RIGHT TO A COPY OF THIS NOTICE (IN PAPER OR ELECTRONIC FORM) AND TO DISCUSS IT WITH [ENTER NAME OR TITLE] AT [PHONE AND EMAIL] IF YOU HAVE ANY QUESTIONS.

Please review it carefully.

YOUR RIGHTS

You have the right to:

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

YOUR CHOICES

With your consent, we can use and share your information as we:

- Treat you
- Run our organization
- Bill for our services
- Fulfill your requests to share information with your consent
- Prevent multiple program enrollments
- Report about court-referred treatment
- Report to prescription drug monitoring programs

OUR USES AND DISCLOSURES

We may use and share your information without your consent as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services

- Administer your health plan
- Help with public health and safety issues
- For your medical emergencies
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions
- Assist with cause of death inquiries
- Communicate within our program and with contractors
- Respond to management and financial audits and program evaluation
- Prevent or reduce crime in our program

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

YOUR RIGHTS

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

Get a copy of health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

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

Provide consent when we use or share your information for most purposes

- You may provide a single consent for all future uses or disclosures for treatment, payment, and health care operations purposes.

- You may provide consent for more limited purposes for example, to only disclose information to another health care provider for your treatment); however, doing so may affect the services we can provide you or how you pay for services.
- You may provide a general consent to share your information through certain third parties, such as a health information network or a research institution, where your treating health care providers can access it.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our health care operations after you have provided consent for all those purposes. We are not required to agree to your request, and we may say “no” if, for example, it could affect your care. If we agree to your request, we may still share this information in the event that you need emergency treatment.
- We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our health care operations with your health insurer. We will say “yes” unless a law requires us to share that information

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 and other government requests

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.

Discuss this notice with someone in our program

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

Choose in advance about fundraising

You have the right to a clear and obvious notice in advance of, and a choice about whether to receive, fundraising communications for our program.

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.

With your consent, we may also use and share your information in the following ways:

- To whomever you name in a consent to share your information
- To prevent multiple enrollments in withdrawal management or maintenance treatment programs
- To report participation in treatment required by the criminal justice system
- To report prescribed substance use disorder treatment medications to a state prescription drug monitoring program when required by law

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.

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

Bill and Pay for your health services

We can use and disclose your health information as we bill or 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: <https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html>

Help with public health and safety issues

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

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

For your medical emergencies

We can share your information during a bona fide medical emergency with the personnel and health care providers responding to your emergency, even when you are unable to consent because of the emergency

Do research

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

Comply with the law

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

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

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

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

We can use or share health information about you:

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

Legal Proceedings and Court Orders

We must follow certain procedures before using or sharing your information for investigations and legal proceedings.

- We will not use or share your information or provide testimony about your information in any civil, administrative, criminal, or legislative proceedings against you without your written consent or a court order.
- We will only respond to a court order to use or share your health information if it is accompanied by a subpoena or other similar legal mandate requiring us to comply.
- We will only use or share your information in proceedings against you based on a court order after we have received notice and an opportunity to be heard or you tell us that you have received notice.
- We may use or share your information to respond to legal proceedings against our program based on a court order and you may not be notified in advance. You have the right to seek to overturn or change the court order after you learn about it.

Assist with cause of death inquiries

We can share patient identifying information about a deceased patient as required or allowed by laws that collect information relating to cause of death.

Communicate within our program and with contractors

We can share your information within our program, with an organization that has administrative control over our program, and with contractors who help us run our program.

Respond to management and financial audits and program evaluation

We can use or share your information to improve the quality of our services, obtain needed credentials, and cooperate with oversight agencies for activities authorized by law, as long as those who view or receive the information agree to destroy or return the information when they are finished and agree not to use it against you.

Prevent or reduce crime in our program

We may report to law enforcement when a patient commits or threatens to commit a crime within our program or against our staff

Redisclosure According to HIPAA

When you consent to uses and disclosures for all future treatment and payment purposes and to run our business, we may share your information with other substance use disorder treatment programs, doctors' offices, and health care businesses for those activities. If the person who receives it is subject to HIPAA, then they are allowed to use and share your information again without your consent for the purposes that HIPAA allows. Your information still cannot be used in legal proceedings against you unless (1) you consent or (2) based on a Part 2 court order and a subpoena (or similar legal requirement).

OUR RESPONSIBILITIES

- We are required to obtain your consent for most uses and sharing of your information.
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

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

- Effective Date: 7/1/2026
- Privacy Officer: Jacob Loll

Important Notice from Norwalk Community School District About Your Prescription Drug Coverage and Medicare

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

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

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

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

When Can You Join A Medicare Drug Plan?

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

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

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

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

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Norwalk Community School District and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage...

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: 07/01/2026

Name of Entity/Sender: Norwalk Community School District

Contact--Position/Office: Rebecca Campbell

Address: 380 Wright Road, Norwalk, IA 50211

Phone Number: 515-981-0676 Ext. 4002

Michelle's Law Enrollment Notice

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

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

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

The Norwalk Community School District group health plan must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary; and

To obtain additional information, please contact Human Resources.

Women's Health and Cancer Rights Act ENROLLMENT NOTICE

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: deductible, 10% coinsurance; deductible, 20% coinsurance; or \$20 copayment. If you would like more information on WHCRA benefits, call your plan administrator at 800-524-9242.

ANNUAL NOTICE

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 800-524-9242 for more information.

Newborns' and Mothers' Health Protection Act

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

Under the Newborns' Act, group health plans may not

restrict benefits for mothers or newborns for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. The 48-hour (or 96-hour) period starts at the time of delivery, unless a woman delivers outside of the hospital. In that case, the period begins at the time of the hospital admission.

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

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

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

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

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

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

YOU ARE PROTECTED FROM BALANCE BILLING FOR: Emergency services

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

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

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

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

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

WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THE FOLLOWING PROTECTIONS:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
 1. Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 2. Cover emergency services by out-of-network providers.
 3. 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.
 4. Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact Wellmark.

Visit www.wellmark.com for more information about your rights under federal law.

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 January 31, 2026. Contact your State for more information on eligibility –

STATE	WEBSITE/EMAIL	PHONE
Alabama Medicaid	myalhipp.com	855-692-5447
Alaska Medicaid	Premium Payment Program: myakhipp.com Medicaid Eligibility: health.alaska.gov/dpa Email: customerservice@myakhipp.com	866-251-4861
Arkansas Medicaid	http://myarhipp.com/	855-MyARHIPP (855-692-7447)
California Medicaid	dhcs.ca.gov/hipp Email: hipp@dhcs.ca.gov	916-445-8322 916-440-5676 (fax)
Colorado Medicaid and CHIP	Medicaid: healthfirstcolorado.com CHIP: hcpf.colorado.gov/child-health-plan-plus HIBI: mycohibi.com	800-221-3943 Relay 711 800-359-1991 Relay 711 855-692-6442
Florida Medicaid	flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html	877-357-3268
Georgia Medicaid	HIPP: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp CHIPRA: 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	HIPP: https://www.in.gov/fssa/dfr/ All other Medicaid: in.gov/medicaid	800-403-0864 800-457-4584
Iowa Medicaid and CHIP	Medicaid: hhs.iowa.gov/programs/welcome-iowa-medicaid CHIP: hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki HIPP: hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp	800-338-8366 800-257-8563 888-346-9562
Kansas Medicaid	kancare.ks.gov	800-792-4884 HIPP: 800-967-4660
Kentucky Medicaid and CHIP	KI-HIPP: chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx KI-HIPP Email: KIHIPPPROGRAM@ky.gov KCHIP: kynect.ky.gov Medicaid: chfs.ky.gov/agencies/dms	KI-HIPP: 855-459-6328 KCHIP: 877-524-4718
Louisiana Medicaid	ldh.la.gov/healthy-louisiana or www.ldh.la.gov/lahipp	Medicaid: 888-342-6207 LaHIPP: 855-618-5488
Maine Medicaid	Enrollment: mymaineconnection.gov/benefits Private health insurance premium: maine.gov/dhhs/ofi/applications-forms	Enroll: 800-442-6003 Private HIP: 800-977-6740 TTY/Relay: 711
Massachusetts Medicaid and CHIP	mass.gov/masshealth/pa Email: masspremassistance@accenture.com	800-862-4840 TTY/Relay: 711
Minnesota Medicaid	mn.gov/dhs/health-care-coverage	800-657-3672
Missouri Medicaid	dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
Montana Medicaid	HIPP: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP HIPP Email: HHSHIPPProgram@mt.gov	800-694-3084
Nebraska Medicaid	ACCESSNebraska.ne.gov	855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
Nevada Medicaid	Medicaid: dhcfp.nv.gov	800-992-0900
New Hampshire Medicaid	dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	603-271-5218 or 800-852-3345, ext. 15218

New Jersey Medicaid and CHIP	Medicaid: state.nj.gov/humanservices/dmahs/clients/medicaid CHIP: njfamilycare.org/index.html	Medicaid: 800-356-1561 CHIP Premium Assist: 609-631-2392 CHIP: 800-701-0710 TTY/Relay: 711
New York Medicaid	health.ny.gov/health_care/medicaid	800-541-2831
North Carolina Medicaid	medicaid.ncdhhs.gov	919-855-4100
North Dakota Medicaid	hhs.nd.gov/healthcare	844-854-4825
Oklahoma Medicaid and CHIP	insureoklahoma.org	888-365-3742
Oregon Medicaid	healthcare.oregon.gov/Pages/index.aspx	800-699-9075
Pennsylvania Medicaid and CHIP	Medicaid: pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html CHIP: dhs.pa.gov/CHIP/Pages/CHIP.aspx	Medicaid: 800-692-7462 CHIP: 800-986-KIDS (5437)
Rhode Island Medicaid and CHIP	eohhs.ri.gov	855-697-4347 or 401-462-0311 (Direct RIte)
South Carolina Medicaid	scdhhs.gov	888-549-0820
South Dakota Medicaid	dss.sd.gov	888-828-0059
Texas Medicaid	hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program	800-440-0493
Utah Medicaid and CHIP	UPP: medicaid.utah.gov/upp/ UPP Email: upp@utah.gov Adult Expansion: medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program: medicaid.utah.gov/buyout-program/ CHIP: chip.utah.gov	UPP: 877-222-2542
Vermont Medicaid	dvha.vermont.gov/members/medicaid/hipp-program	800-250-8427
Virginia Medicaid and CHIP	coverva.dmas.virginia.gov/learn/premium-assistance/famis-select coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs	Medicaid/CHIP: 800-432-5924
Washington Medicaid	hca.wa.gov	800-562-3022
West Virginia Medicaid and CHIP	dhhr.wv.gov/bms/ mywvhipp.com/	Medicaid: 304-558-1700 CHIP: 855-699-8447
Wisconsin Medicaid and CHIP	dhs.wisconsin.gov/badgercareplus/p-10095.htm	800-362-3002
Wyoming Medicaid	health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility	800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov
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 ebbsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Patient Protection Notice

Wellmark Point of Service plans generally require 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 Rebecca Campbell at 515-981-0676 Ext. 4002.

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, contact Rebecca Campbell at 515-981-0676 Ext. 4002.

