CHEROKEE SCHOOL DISTRICT COMMUNITY

Group Health Plan Basics

- **HEALTH PLANS AVAILABLE UNDER OUR CAFETERIA PLAN**
  - Deductible $750 / $1250 (single / family)
    - Co-Insurance 10% / 20% (in / out of network)
    - Out of Pocket Maximums $1,250 / $2,500
    - Office Visit Copay $20
    - Prescription Copays $15 / $30 or $15 / $20

- **NEW RATES BEGINNING JULY 1, 2025**
  - Single Insurance
    - $750 Deductible | $15 / $30 Prescription Copay
      - *Paid by the District for Teachers & 12-month employees*
      - *Paras, Cooks, & 10-month Secretaries pay $100/month*
    - $750 Deductible | $15 / $20 Prescription Copay - $24.58/month
  - Family Insurance
    - $750 Deductible | $15 / $30 Prescription Copay - $1,334.43/month
    - $750 Deductible | $15 / $20 Prescription Copay - $1,371.36/month

Cherokee CSD

July 1, 2025 to June 30, 2026

	Wellmark Blue Cross Blue Shield		*Employee Plan*	
	In Network	**Out of Network**	**In Network**	**Out of Network**
Deductible				
Single	$2,700	$2,700	$750	$750
Family	$5,400	$5,400	$1,250	$1,250
Coinsurance (Major Med)				
Single	20%	40%	10%	20%
Family	20%	40%	10%	20%
Coinsurance (D/A, M/N)				
Single	20%	40%	10%	20%
Family	20%	40%	10%	20%
Maximum Out of Pocket				
Single	$5,400	$5,400	$1,250	$1,500
Family	$10,800	$10,800	$2,500	$2,500
Office Visit Copays	$25	Deductible and co-insurance	$20	Deductible and co-insurance
Preventative Care Office Visits	$25 with limitations; if provided by hospital, see hospital	Deductible and co-insurance	$20 with limitations; if provided by hospital, see hospital	Deductible and co-insurance
ER	Deductible and co-insurance	Deductible and co-insurance	Deductible and co-insurance	Deductible and co-insurance
Hospital	Deductible and co-insurance	Deductible and co-insurance	Deductible and co-insurance	Deductible and co-insurance
Prescription	$/$40	N/A	5/20-OR-$15/30	N/A

Note: Always refer to policy for exact benefits

Comments: Definitions: I/P=Inpatient O/P= Outpatient

Co-pay=Employee's share of the cost

Co-pays do not count toward maximum out of pocket

D/A=Drug and Alcohol M/N= Mental and Nervous

Wellmark

Wellmark Blue Cross and Blue Shield of Iowa and
Wellmark Health Plan of Iowa, Inc. are independent
licensees of the Blue Cross and Blue Shield Association.

Group Employee Application for Health Insurance

Wellmark Blue Cross and Blue Shield of Iowa
updatesgroupmembership@wellmark.com

Failure to fill out this application completely may result in a delay of coverage.

Effective Date _____/_____/_____

☐ Special Enrollee ☐ Change ☐ Open Enrollment Period ☐ Newly Eligible

A. Employer Information (Completed by Employer)

Employer Name_____

Employer Group Number_____ Subgroup Number_____

Department Number_____

B. Employee Information

Name (First, MI, Last)_____

Address Line 1 (Street Address or Suite#)_____

Address Line 2 (PO Box, Street Address)_____

City_____ State_____ ZIP_____

Home Phone Number (_____)_____ Cell Phone Number (_____)_____

Email Address_____

Date of Birth _____/_____/_____ (mm/dd/yyyy) Gender: ☐ Male ☐ Female Status: ☐ Single ☐ Married

Social Security Number/Tax Identification Number _____
(Social Security Number (SSN) or Tax Identification Number (TIN) must be provided.)

Date of Hire (required)_____/_____/_____ (mm/dd/yyyy)

Employment Status: ☐ Full-Time ☐ Part-Time ☐ COBRA ☐ Retiree ☐ Seasonal

Health: ☐ Employee ☐ Employee/spouse ☐ Employee/child(ren) ☐ Employee/spouse/child(ren)

Health Product ID* _____ ☐ **Not Elected**

*If you're enrolling in an HMO/WHPI plan a Primary Care Provider (PCP) must be elected for each family member. Please visit www.myWellmark.com to select your PCP.

As a Wellmark contract holder, you will receive a Summary of Benefits and Coverage (SBC) that outlines important information about your coverage. You can also access Wellmark.com/Inform to help you make the best decisions for you and your family. This site includes important information on your prescription drug coverage, like the accessibility and availability of prescription drugs, how to request a current drug list and the process for requesting an exception to the drug list. You also can find a list of participating providers and facilities, and how to obtain a prior authorization. For more information, or if you have any questions, you can call the Wellmark Customer Service number located on the back of your ID card.

C. Enrollment Reason or Event

Special Enrollment Event Reason:

☐ Birth
☐ Marriage
☐ Divorce
☐ Adoption or placement for adoption
☐ Court-ordered coverage
☐ Other _____
☐ Legal guardianship
☐ Foster child placement
☐ Involuntary loss of creditable coverage
☐ Permanent move to Iowa
☐ Returning from military service

List date of special enrollment event _____/_____/_____ (mm/dd/yyyy) (or last day of coverage)

Employee Name (First, Last)	Social Security Number / Tax Identification Number

D. Members/enrollees Covered If you need to list more than four dependents, please write all necessary information on a separate sheet of paper and attach to this application. Your employer determines eligibility for coverage. Please confirm with your employer that the dependent types listed below are eligible.

Name (First, MI, Last)		Date of Birth (mm/dd/yyyy)	Social Security Number/ Tax Identification Number[1]	Gender	FT Student?[2]	Disabled?[2]
Spouse		/ /	a. ☐ SSN/TIN ____________________ b. ☐ Does not have an SSN/TIN	☐ Male ☐ Female	N/A	☐ Yes
Dependent		/ /	a. ☐ SSN/TIN ____________________ b. ☐ Does not have an SSN/TIN	☐ Male ☐ Female	☐ Yes	☐ Yes
Dependent		/ /	a. ☐ SSN/TIN ____________________ b. ☐ Does not have an SSN/TIN	☐ Male ☐ Female	☐ Yes	☐ Yes
Dependent		/ /	a. ☐ SSN/TIN ____________________ b. ☐ Does not have an SSN/TIN	☐ Male ☐ Female	☐ Yes	☐ Yes
Dependent		/ /	a. ☐ SSN/TIN ____________________ b. ☐ Does not have an SSN/TIN	☐ Male ☐ Female	☐ Yes	☐ Yes

[1]The IRS requires Wellmark to collect SSNs/TINs for federal reporting purposes. Your employer will follow up with you to collect this information if you do not complete a. or b. for each person listed. Failure to provide the SSN/TIN information may result in a monetary penalty, per violation, assessed to you by the IRS.

[2]If your plan covers dependent(s) age 26 or older, they must be unmarried and either a full-time student or a disabled dependent. Please contact your Wellmark representative for more information.

E. Medicare Coverage

Are you and/or anyone listed in the Dependent Information section Social Security disabled? ☐ Yes ☐ No

If yes, name____

Are you and/or anyone listed in the Dependent Information section enrolled in Medicare? **(Absence of a response will be considered as a response of "No")** ☐ Yes ☐ No

If yes, complete as appropriate:

Name[3]	Medicare ID	Effective Dates		
		Part A	Part B	Part D
		/ /	/ /	/ /
		/ /	/ /	/ /

[3]If you need to list more than two members, please write all necessary information on a separate piece of paper and attach to this application.

Employee Name (First, Last)	Social Security Number / Tax Identification Number

F. Other Health Coverage Information (Required)

☐ Yes ☐ No Will you, your spouse, or your dependents keep other health coverage in addition to this Wellmark, Inc. coverage?

If yes, please complete the following:

Policyholder Name (First and Last)_____

Please list those covered by the other health plan(s)_____

Policy Number_____ Effective Date _____/_____/_____

Insurance Company/HMO Name_____

Is there a divorce decree/court order that requires one parent to provide health insurance coverage for any dependent?

☐ Yes ☐ No If yes, please complete the following:

List dependent(s)_____

List name of person required to provide health insurance_____

List name of person who has primary physical custody_____

G. Important Information Regarding Waiver Enrollment

If you are declining enrollment 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 or 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), or if you lose eligibility for coverage under Medicaid or CHIP or become eligible for Medicaid or CHIP premium assistance. You may be able to enroll if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption. However, you must request enrollment within the time specified by your employer or group sponsor after the qualifying event.

Please note that if you or your dependents are not covered by minimum essential coverage, you may be responsible for individual shared responsibility payments when filing your federal income tax return. Also, by declining the coverage offered by your employer, you or your dependents may not be eligible for Marketplace coverage subsidies.

To request special enrollment or obtain more information, refer to your Summary Plan Description (SPD), coverage manual, other benefits documents, or contact your employer.

H. Authorization and Certification

I certify that I am legally authorized to apply for coverage for myself and all other persons named in this application. I understand that I am completing this application for the coverage sponsored by my employer or group sponsor and offered by Wellmark, Inc., doing business as Wellmark Blue Cross and Blue Shield of Iowa, or Wellmark Health Plan of Iowa, Inc. (each referenced herein as "Wellmark").

I certify that, after this application was completed, I carefully and fully read it, that the statements and answers set forth are full, true, and correct to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that my employer or group sponsor will rely on the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or concealed any material fact, my employer or group sponsor is entitled to declare the contracts applied for void and to refuse allowance on benefits to any person thereunder. I understand and grant authorization for my employer, group sponsor, consultant, or Wellmark agent to electronically submit the information provided by me on this signed application for enrollment purposes.

I acknowledge I have received or have been advised and understand I will receive from my employer the Summary of Benefits and Coverage (SBC).

Providing Social Security Numbers or Tax Identification Numbers

Wellmark requires Social Security numbers or other tax identification numbers for federal reporting purposes. If Wellmark does not have Social Security or tax identification numbers for each enrollee, Wellmark or my employer may be unable to report and send information needed to complete federal tax returns. If Social Security numbers or tax identification numbers are not provided for all individuals covered, Wellmark or my employer may contact the primary policyholder to obtain the information. If I do not provide the Social Security numbers or tax identification numbers for these purposes, I may be subject to a monetary penalty imposed by the internal revenue service.

HSA Coverage

In the event I have selected a High Deductible Health Plan, I understand that enrolling in such coverage does not guarantee that I am or will be eligible to make contributions to an HSA or that contributions can be made to an HSA on my behalf.

Employee Name (First, Last)	Social Security Number / Tax Identification Number

H. Authorization and Certification, cont'd.

Consent to Contact Me Via Residential Telephone, Cellular Phone, Text and Email Messages

☐ By checking the box and entering my signature on this application, I hereby provide my consent to Wellmark to contact me about Wellmark policy or products and services that may be available to me. Wellmark may provide this information to me using residential telephone, cellular telephone or wireless device, text message or email contact information provided to Wellmark from time to time. If I provide a telephone number for voice calls, I understand that Wellmark may contact me via live or prerecorded calls. I give Wellmark permission to use my personal data (including personally identifiable information) in accordance with Wellmark's privacy policy to determine the types of products and services that may be offered to me. I understand the telephone company or other communications carrier may impose charges for these contacts and that I am not required to give this consent to purchase any goods or services. I understand I may revoke this consent at any time by calling the number located on the back of my Wellmark ID Card.

I understand that I have the right to refuse to sign this authorization, but that Wellmark will then have the right to condition eligibility determination and enrollment on the receipt of this signed authorization.

I authorize the Wellmark agent or agency who is identified with this application or my employer's group application to enter my application information through Wellmark's electronic enrollment process. In the event of any discrepancy between this paper application form and the information entered electronically may be considered the source of records, and I may contact Wellmark to make any changes to my enrollment information. Wellmark authorized agents are required to retain this original paper application for 11 years.

I have read and understand the Important Information Regarding Waiver of Enrollment and Authorization and Certification language on this application and acknowledge receipt of a fully completed copy of this application.

Employee Signature_____ **Date** _____/_____/_____

If applicant is a minor, please sign below.
Parent/Legal Guardian Printed Name:_____

Parent/Legal Guardian Signature:_____ **Date** _____/_____/_____

Wellmark

Wellmark Language Assistance

Discrimination is against the law

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

Wellmark

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

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

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

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

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

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

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

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

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

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

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

تنبيه: إذا كنت تتحدث اللغة العربية, فإننا نوفر لك خدمات المساعدة اللغوية، المجانية. اتصل بالرقم ٨٠٠-٥٢٤-٩٢٤٢ أو (خدمة الهاتف النصي: ٨٨٨-٧٨١-٤٢٦٢).

ສິ່ງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານ ໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ທີ່. (TTY: 888-781-4262.)

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

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

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

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

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

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

တၢ်ဒုးသ့ၣ်ညါ–နမ့ၢ်ကတိၤကညီကျိာ်,ကျိာ်တၢ်မၤစၢၤတၢ်ဖံးတၢ်မၤတဖၣ်,လၢတဘၣ်လၢာ်ဘူးလဲ,အိၣ်လၢနဂီၢ်လီၤ.ဆဲးကျိးဆူ ၈၀၀–၅၂၄–၉၂၄၂မ့တမ့ၢ်(TTY:၈၈၈–၇၈၁–၄၂၆၂)တက့ၢ်.

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

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

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

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

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

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

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