2024
ENROLLMENT VERIFICATION FORM
HENRY-STARK COUNTIES SPECIAL EDUCATION DISTRICT

OPEN ENROLLMENT ANNOUNCEMENT

January 1, 2024, is the renewal date and open enrollment period for our employee benefit program.
We are very excited to offer our new Springfield Clinic Advantage health plan. This will allow us to improve access to care, with no premium increase for this year.
We will also be offering an improved dental program, at a lower rate!!
Our employer paid life benefit will increase to $25,000 and our new voluntary life insurance offering will provide improved underwriting provisions.
Open enrollment is the period of time offered on an annual basis, allowing you to elect to enroll in our programs or make changes to your current coverage.
You are able to add dependents that are not currently covered or switch from one health plan to the other.
Eligible dependent children to age 26 (30 military) will be covered regardless of marital, student or employment status.
If you do not enroll now, you will not be able to enroll until next year's open enrollment period, unless you would experience a qualifying event during the plan year.
Steve or Lance Leesman would be glad to assist you with any decisions or questions. Their contact information is enclosed.
Members or dependents eligible or participating in Medicare should check with Steve or Human Resources to determine any positive or negative impact to your health plan.

All eligible employees must confirm your health, dental, vision and life elections for the coming year, even if making no changes.
Sign this form and return to Jennifer Harker by Wednesday, November 29th.

EMPLOYEE INFORMATION

Social Security Number			Effective Date	
Last Name	First Name		Middle Initial	Male or Female
Street Address	City	State		Zip Code
Date of Birth	_____Single ____Widowed _____Married ____Divorced	Date of Full Time Employment		
Phone Number	Job Title	Hours worked per week		

BENEFIT COVERAGE (CHECK ELIGIBLE COVERAGE APPLIED FOR)

IN THE OPTIONS BELOW, THE FIRST COLUMN RELFECTS USING THE $1,500 STIPEND TO OFFSET THE COST OF YOUR HEALTH INSURANCE. IF YOU OPT OUT OF USING IT TOWARD THE COST OF YOUR HEALTH INSURANCE, IT WILL BE PUT INTO AN FSA ACCOUNT (TASC- DEBIT CARD), AND YOUR PER PAY COST WILL BE THE AMOUNT IN THE SECOND COLUMN.

CONSOCIATE BRONZE SCA - 22 PAYS			CONSOCIATE BRONZE SCA - 26 PAYS			UNITED HEALTHCARE DENTAL		
	Without Flex Account	With Flex Account		Without Flex Account	With Flex Account		22 PAY PERIODS	26 PAY PERIODS
____Employee Only	_____$40.91	_____$109.09	____Employee Only	_____$34.62	_____$92.31	____Employee Only	$0.00	$0.00
____Emp + Spouse	_____$468.66	_____$536.84	____Emp + Spouse	_____$396.56	_____$454.25	____Emp + Spouse	$22.82	$19.30
____Emp + Child(ren)	_____$404.03	_____$472.21	____Emp + Child(ren)	_____$341.88	_____$399.57	____Emp + Child(ren)	$39.57	$33.48
____Emp + Family	_____$831.78	_____$899.96	____Emp + Family	_____$703.82	_____$761.51	____Emp + Family	$39.57	$33.48
____Waive Coverage			____Waive Coverage			____Waive Coverage		

CONSOCIATE SILVER SCA - 22 PAYS			CONSOCIATE SILVER SCA - 26 PAYS			HUMANA VISION		
	Without Flex Account	With Flex Account		Without Flex Account	With Flex Account		22 PAY PERIODS	26 PAY PERIODS
____Employee Only	_____$40.91	_____$109.09	____Employee Only	_____$34.62	_____$92.31	____Employee Only	$7.75	$6.56
____Emp + Spouse	_____$427.77	_____$495.95	____Emp + Spouse	_____$361.96	_____$419.65	____Emp + Spouse	$13.07	$11.06
____Emp + Child(ren)	_____$366.52	_____$434.70	____Emp + Child(ren)	_____$310.41	_____$367.83	____Emp + Child(ren)	$13.33	$11.28
____Emp + Family	_____$771.88	_____$840.06	____Emp + Family	_____$653.14	_____$710.83	____Emp + Family	$21.08	$17.84
____Waive Coverage			____Waive Coverage			____Waive Coverage		

UNITED HEALTHCARE BASIC LIFE/AD&D $25,000: EMPLOYER PAID

UNITED HEALTHCARE VOLUNTARY LIFE/AD&D: EMPLOYEE	UNITED HEALTHCARE VOLUNTARY LIFE: SPOUSE	UNITED HEALTHCARE VOLUNTARY LIFE: CHILD(REN)
PREMIUM SUBJECT TO SCHEDULE: SEE HANDOUT	**PREMIUM SUBJECT TO SCHEDULE: SEE HANDOUT**	**PREMIUM SUBJECT TO SCHEDULE: SEE HANDOUT**
_____Yes, I would like to enroll.	_____Yes, I would like to enroll my spouse.	_____Yes, I would like to enroll my child(ren).
Coverage Amount Electing: $	Coverage Amount Electing: $	Coverage Amount Electing: $10,000
Initial if you are electing to waive this coverage: _____	Initial if you are electing to waive this coverage: _____	Initial if you are electing to waive this coverage: _____

NAME OF COVERED DEPENDENT(S)

First Name	Last Name	Soc. Sec. Number	Relationship	Gender	Date of Birth

EMPLOYEE SIGNATURE

I hereby represent that my answers and statements as completed on this form are correct, to the best of my knowledge. I certify that each dependent named as covered under the Medical Benefits plan is considered a "dependent" as defined in the plan.

Signed by: X _____ **Date:** _____

2023 PREMIUMS for 22 Pay Scale					2023 PREMIUMS for 26 Pay Scale			
UHC - Dental Insurance DPPO					**UHC - Dental Insurance DPPO**			
ANNUALLY				**MONTHLY**	**ANNUALLY**			
Type of Coverage	**Annual Premium**	**Board Paid Amount**	**Net Employee Cost**		**Type of Coverage**	**Annual Premium**	**Board Paid Amount**	**Net Employee Cost**
Employee	$498.00	$498.00	$0.00	$41.50	Employee	$498.00	$498.00	$0.00
Employee +1	$999.96	$498.00	$501.96	$83.33	Employee +1	$999.96	$498.00	$501.96
Employee + Children	$1,368.60	$498.00	$870.60	$114.05	Employee + Child(ren)	$1,368.60	$498.00	$870.60
Family	$1,368.60	$498.00	$870.60	$114.05	Family	$1,368.60	$498.00	$870.60
PER PAY			**22 PAYS**		**PER PAY**			**26 PAYS**
Type of Coverage	**Per Pay Premium**	**Board Paid Amount**	**Net Employee Cost**		**Type of Coverage**	**Per Pay Premium**	**Board Paid Amount**	**Net Employee Cost**
Employee	$22.64	$22.64	$0.00		Employee	$19.16	$19.16	$0.00
Employee +1	$45.46	$22.64	$22.82		Employee +1	$38.46	$19.16	$19.30
Employee + Children	$62.21	$22.64	$39.57		Employee + Child(ren)	$52.64	$19.16	$33.48
Family	$62.21	$22.64	$39.57		Family	$52.64	$19.16	$33.48
Humana - Vision Insurance					**Humana - Vision Insurance**			
ANNUALLY				**MONTHLY**	**ANNUALLY**			
Type of Coverage	**Annual Premium**	**Board Paid Amount**	**Net Employee Cost**		**Type of Coverage**	**Annual Premium**	**Board Paid Amount**	**Net Employee Cost**
Employee	$170.52	$0.00	$170.52	$14.21	Employee	$170.52	$0.00	$170.52
Employee + Spouse	$287.52	$0.00	$287.52	$23.96	Employee + Spouse	$287.52	$0.00	$287.52
Employee + Child(ren)	$293.28	$0.00	$293.28	$24.44	Employee + Child(ren)	$293.28	$0.00	$293.28
Family	$463.80	$0.00	$463.80	$38.65	Family	$463.80	$0.00	$463.80
PER PAY			**22 PAYS**		**PER PAY**			**26 PAYS**
Type of Coverage	**Per Pay Premium**	**Board Paid Amount**	**Net Employee Cost**		**Type of Coverage**	**Per Pay Premium**	**Board Paid Amount**	**Net Employee Cost**
Employee	$7.75	$0.00	$7.75		Employee	$6.56	$0.00	$6.56
Employee + Spouse	$13.07	$0.00	$13.07		Employee + Spouse	$11.06	$0.00	$11.06
Employee + Child(ren)	$13.33	$0.00	$13.33		Employee + Child(ren)	$11.28	$0.00	$11.28
Family	$21.08	$0.00	$21.08		Family	$17.84	$0.00	$17.84
UHC - Life and AD&D Insurance					**UHC - Life and AD&D Insurance**			
ANNUALLY				**MONTHLY**	**ANNUALLY**			
Type of Coverage	**Annual Premium**	**Board Paid Amount**	**Net Employee Cost**		**Type of Coverage**	**Annual Premium**	**Board Paid Amount**	**Net Employee Cost**
Employee	$24.00	$24.00	$0.00	$2.00	Employee	$24.00	$24.00	$0.00
PER PAY			**22 PAYS**		**PER PAY**			**26 PAYS**
Type of Coverage	**Per Pay Premium**	**Board Paid Amount**	**Net Employee Cost**		**Type of Coverage**	**Per Pay Premium**	**Board Paid Amount**	**Net Employee Cost**
Employee	$1.09	$1.09	$0.00		Employee	$0.92	$0.92	$0.00

2024 PREMIUMS for 22 Pay Scale					2024 PREMIUMS for 26 Pay Scale			
UHC - Dental Insurance DPPO					**UHC - Dental Insurance DPPO**			
ANNUALLY				**MONTHLY**	**ANNUALLY**			
Type of Coverage	**Annual Premium**	**Board Paid Amount**	**Net Employee Cost**		**Type of Coverage**	**Annual Premium**	**Board Paid Amount**	**Net Employee Cost**
Employee	$498.00	$498.00	$0.00	$41.50	Employee	$498.00	$498.00	$0.00
Employee +1	$999.96	$498.00	$501.96	$83.33	Employee +1	$999.96	$498.00	$501.96
Employee + Children	$1,368.60	$498.00	$870.60	$114.05	Employee + Child(ren)	$1,368.60	$498.00	$870.60
Family	$1,368.60	$498.00	$870.60	$114.05	Family	$1,368.60	$498.00	$870.60
PER PAY			**22 PAYS**		**PER PAY**			**26 PAYS**
Type of Coverage	**Per Pay Premium**	**Board Paid Amount**	**Net Employee Cost**		**Type of Coverage**	**Per Pay Premium**	**Board Paid Amount**	**Net Employee Cost**
Employee	$22.64	$22.64	$0.00		Employee	$19.16	$19.16	$0.00
Employee +1	$45.46	$22.64	$22.82		Employee +1	$38.46	$19.16	$19.30
Employee + Children	$62.21	$22.64	$39.57		Employee + Child(ren)	$52.64	$19.16	$33.48
Family	$62.21	$22.64	$39.57		Family	$52.64	$19.16	$33.48
Humana - Vision Insurance					**Humana - Vision Insurance**			
ANNUALLY				**MONTHLY**	**ANNUALLY**			
Type of Coverage	**Annual Premium**	**Board Paid Amount**	**Net Employee Cost**		**Type of Coverage**	**Annual Premium**	**Board Paid Amount**	**Net Employee Cost**
Employee	$170.52	$0.00	$170.52	$14.21	Employee	$170.52	$0.00	$170.52
Employee + Spouse	$287.52	$0.00	$287.52	$23.96	Employee + Spouse	$287.52	$0.00	$287.52
Employee + Child(ren)	$293.28	$0.00	$293.28	$24.44	Employee + Child(ren)	$293.28	$0.00	$293.28
Family	$463.80	$0.00	$463.80	$38.65	Family	$463.80	$0.00	$463.80
PER PAY			**22 PAYS**		**PER PAY**			**26 PAYS**
Type of Coverage	**Per Pay Premium**	**Board Paid Amount**	**Net Employee Cost**		**Type of Coverage**	**Per Pay Premium**	**Board Paid Amount**	**Net Employee Cost**
Employee	$7.75	$0.00	$7.75		Employee	$6.56	$0.00	$6.56
Employee + Spouse	$13.07	$0.00	$13.07		Employee + Spouse	$11.06	$0.00	$11.06
Employee + Child(ren)	$13.33	$0.00	$13.33		Employee + Child(ren)	$11.28	$0.00	$11.28
Family	$21.08	$0.00	$21.08		Family	$17.84	$0.00	$17.84
UHC - Life and AD&D Insurance					**UHC - Life and AD&D Insurance**			
ANNUALLY				**MONTHLY**	**ANNUALLY**			
Type of Coverage	**Annual Premium**	**Board Paid Amount**	**Net Employee Cost**		**Type of Coverage**	**Annual Premium**	**Board Paid Amount**	**Net Employee Cost**
Employee	$24.00	$24.00	$0.00	$2.00	Employee	$24.00	$24.00	$0.00
PER PAY			**22 PAYS**		**PER PAY**			**26 PAYS**
Type of Coverage	**Per Pay Premium**	**Board Paid Amount**	**Net Employee Cost**		**Type of Coverage**	**Per Pay Premium**	**Board Paid Amount**	**Net Employee Cost**
Employee	$1.09	$1.09	$0.00		Employee	$0.92	$0.92	$0.00

Beneficiary Form
Group Term Life Insurance

Important Note: This Beneficiary Designation cancels any prior beneficiary designation and shall be effective on the date received by the Company			
Policyholder:			
Individual Covered Person	SSN#:	Phone#	
Street Address (please include apartment # as applicable)	City	State	Zip

THE BENEFICIARY FOR THE POLICY SHALL BE:

Primary Beneficiary			
Name	**Address**	**SSN#**	**% of Death Benefit Payable to Beneficiary (must total 100%)**
In the event, and only in the event, that all Primary Beneficiaries predecease me, then the proceeds shall be payable to the following Contingent Beneficiaries			
Contingent Beneficiary			
Name	**Address**	**SSN#**	**% of Death Benefit Payable to Beneficiary (must total 100%)**

Insured's Signature:_____
Insured's Printed Name: _____
Date: _____

In case I name more than one person in a group of beneficiaries, whether as the Primary beneficiaries or as the Contingent beneficiaries, then unless I otherwise direct in writing above, each designated beneficiary in a group shall share equally in the amount to be paid under the covering policy. In the event any designated beneficiary (ies) in a group predeceases me, then the remaining beneficiary (ies) in that group of beneficiaries shall share equally in the life insurance proceeds to be paid under the policy.

2024
BENEFIT CONTACTS
HENRY-STARK COUNTIES S.E.D.

STEVE EMAIL: Steve@miaminier.com

STEVE CELL: 309-275-7685

LANCE EMAIL: Lance@miaminier.com

LANCE CELL: 309-275-8884

MIDWESTERN INSURANCE PHONE: 309-392-2018

MIDWESTERN INSURANCE FAX: 309-392-2250

CONSOCIATE PHONE: 800-798-2422

CONSOCIATE WEBSITE: www.consociatehealth.com

UNITED HEALTHCARE PHONE: 866-633-2446

UNITED HEALTHCARE WEBSITE: www.myuhc.com

HUMANA PHONE: 800-448-6262

HUMANA WEBSITE: www.humana.com

Employee Health Plan Members

We are here to serve you.

The customer service representatives who staff our best-in-class call center are happy to assist with any need or concern, and our online portal is also an easy way to access information.

Reach our live call center
800.798.2422

Hours of operation
Monday-Thursday 7am-6pm CST
Friday 7am-5pm CST

Email
customerservice@consociate.com

Call or email us with any questions, including:

- Finding a PPO network provider
- Benefit questions
- Claim questions

Access the online portal
consociatehealth.com

- Click on Members, then click on VIVO Claims Access.

Online portal available 24/7:

- PPO providers list – consociatehealth.com/ppo-search
- Online image of your ID card
- Claims history
- Benefits at a Glance (summary)
- Verification of Benefits (detailed)
- Explanation of Benefits
- Resources including forms and plan information
- Important announcements

We are proud to be part of your employer sponsored health plan, and look forward to serving you.

CONSOCIATE HEALTH

Henry Stark Counties Special Education District #801

Summary of Benefits

Basic Life and AD&D Insurance

Supplemental Life and AD&D Insurance

Effective Date	January 1, 2024
Eligibility	All Active Full Time Employees working a minimum of 30 hours per week.
Non-Contributory Basic Employee Life and AD&D Benefit	$25,000 Guarantee Issue Limit: $25,000
Employee Supplemental Life and AD&D Benefit	Increments of $10,000, to a maximum of $500,000, not to exceed 5 times Annual Earnings. Guarantee Issue Limit: $150,000
Spouse Supplemental Life and AD&D	If you elect Supplemental Life and AD&D Insurance for yourself, you may choose to purchase Spouse Supplemental Life and AD&D Insurance: Increments of $5,000, to a maximum of $250,000 not to exceed 50.0% of Employee amount. Guarantee Issue Limit: $20,000 You may not elect coverage for your Spouse if they are already covered as an Employee under this policy.
Child(ren) Supplemental Life and AD&D	If you elect Supplemental Life and AD&D Insurance for yourself, you may choose to purchase Child(ren)* Supplemental Life and AD&D Insurance: Increments of $2,000, to a maximum of $10,000 not to exceed 50.0% of Employee amount for each child. Guarantee Issue Limit: $10,000 Note: No benefit is paid for a child under 14 days old.
	Please see the certificate of coverage for the complete Benefit Schedule.
Additional Benefits	
Waiver of Premium	If you become totally disabled your life insurance premium may be waived. See the certificate of coverage for details
Accelerated Death Benefit	If you are diagnosed as terminally ill you may receive payment of a portion of your Life Insurance. The remaining amount of your Life Insurance would be paid to your beneficiary when you die.
Conversion	Included. Please see the certificate of coverage for provision details.
Portability	Included. Please see the certificate of coverage for provision details.
Benefit Reductions	***Initial benefit age reduction is the percent of the face amount, any subsequent benefit age reductions are the percent of the original amounts.***
Basic EE Life and AD&D	65% at age 65, 45% at age 70, 30% at age 75, 20% at age 80, 15% at age 85 Coverage terminates at employee's retirement
Supplemental EE Life and AD&D	65% at age 65, 45% at age 70, 30% at age 75, 20% at age 80, 15% at age 85 Coverage terminates at employee's retirement
Spouse Supplemental Life and AD&D	65% at age 65, 45% at age 70, 30% at age 75, 20% at age 80, 15% at age 85 Coverage terminates at employee's retirement
Evidence of Insurability Requirements	
	True Open Enrollment for January 1, 2024: A one-time exception has been made to allow an Actively at Work employee, including an employee not currently enrolled for Supplemental Life coverage, to elect an amount of Supplemental Life coverage without providing proof of good health as follows: For employees insured under the Supplemental Life plan on December 31, 2023: - Employees insured under the Supplemental Life plan are eligible to increase their Supplemental Life coverage without providing proof of good health, not to exceed the Guaranteed Issue limit. All requests must be received by January 31, 2024 For employees who are not insured under the Supplemental Life plan on December 31, 2023: - Employees not insured under the Supplemental Life plan are eligible to enroll for coverage without providing proof of good health not to exceed the Guaranteed Issue limit. All requests must be received by January 31, 2024 Note: These amounts are prior to any age reduction being taken.
	Spouse: In addition to the one-time exception allowing an employee to increase his/her Supplemental Life coverage, the employee may also elect to increase the Supplemental Spouse Life coverage, not to exceed the Spouse Life Guarantee Issue limit without providing proof of good health.
	Child(ren) - You may elect up to the Guarantee Issue limit.
	Late Entrant (did not enroll within 31 days of eligibility): For Employee and Spouse coverage, evidence of good health/insurability is required for any requested amount.

This benefit summary is an overview of your Insurance. Once a group policy is issued to your employer, a certificate of coverage will be available to explain your benefits in detail.

Important Details

This Summary of Benefits sheet is an overview of the Life Insurance being offered and is provided for illustrative purposes only and is not a contract. It in no way changes or affects the policy as actually issued. Only the insurance policy issued to the policyholder (your employer) can fully describe all of the provisions, terms, conditions, limitations and exclusions of your insurance coverage. In the event of any difference between the Summary of Benefits sheet and the insurance policy, the terms of the insurance policy apply.

Once a group policy is issued to your employer, a certificate of coverage will be available to explain your benefits in detail.

You must be Actively at Work with your employer on the day your coverage takes effect.

This coverage, like most group benefit insurance, requires that a certain percentage of eligible employees participate. If that group participation minimum is not met, the insurance coverage that you have elected may not be in effect.

Annual Earnings are defined in UnitedHealthcare's contract with your employer.

Supplemental Life Insurance can be purchased without Supplemental AD&D Insurance, however you cannot purchase Supplemental AD&D Insurance without Supplemental Life Insurance. If you do elect Supplemental AD&D Insurance, the amount elected must not exceed the amount of Supplemental Life elected and approved.

This applies to you, your Spouse and your Dependent Child(ren).

Eligible Child(ren) are covered To age 26.

Benefit Reduction Examples:
- 65% at age 65, 50% at age 70: Coverage reduces to 65% of the face amount at age 65; to 50% of the original amount at age 70.

- 65% at age 65, 45% at age 70, 25% at age 75: Coverage reduces to 65% of the face amount at age 65; to 45% of the original amount at age 70; to 25% of the original amount at age 75.

Exclusions:
AD&D Insurance does not cover losses caused by or contributed by:

Disease, bodily or mental infirmity, suicide or intentionally self-inflicted injury, commission of an assault or felony, war, use of any drug unless prescribed by physician, driving while intoxicated, engaging in any hazardous activities, or travel in a private aircraft.*

Other exclusions may apply depending upon your coverage. Once a group policy is issued to your employer, a certificate of coverage will be available to explain your benefits in detail.

As is standard with most term life Insurance, this Insurance coverage includes certain limitations and exclusions:
Death by suicide 2 Years*.

** Some state variations may apply*

Value-Added Services (All features may not apply. Some states may have restrictions.)

Beneficiary Services: Provides beneficiaries with services for grief consultation, financial/legal assistance and referral to community resources. For more information, call 866-302-4480.

· Toll-free line available 24/7 as well as referrals for face-to-face counseling. Specialists provide in-depth consultation, information and referral to community resources such as grief support groups. Includes access to a national network of credentialed clinicians for grief and loss counseling. Beneficiaries receive two complimentary sessions.**

· Financial and Legal Services. Telephonic access to financial consultants for assistance with financial decision-making. Includes access to a network of 22,000 attorneys for either a 30-minute telephonic or an in-person consultation. Clients may retain the same attorney for representation at a discounted rate. CLC, Inc. provides access to legal services.

· Communication Support. We provide a "Beneficiary Kit" with informational resources to help beneficiaries with the emotional and financial process that follows the loss of a loved one.

Wealth Management Account: An enhanced benefit payment process. Life claim proceeds in excess of $5,000 will automatically be deposited into an OptumBank Wealth Management Account (WMA). Beneficiaries receive an FDIC-insured, beneficiary-owned, interest earning account with convenient access to their claim proceeds via debit card or checkbook.***

**Beneficiary Services offered through United Behavioral Health, a company of UnitedHealth Group.

***Eligibility for automatic deposit into an OptumHealth Bank Wealth Management Account is subject to qualifying conditions evaluated by OptumHealth Bank and UnitedHealthcare Specialty Benefits at the time of claim review to include limited availability in certain states. For more information please contact your Specialty Benefits representative. OptumHealth Bank, Member FDIC, is part of the financial services unit of OptumHealth, a health and wellness company serving more than 60 million people. OptumHealth is a UnitedHealth Group (NYSE:UNH) company.

UnitedHealthcare Life and Disability products are provided by UnitedHealthcare Insurance Company, and certain products in California by Unimerica Life Insurance Company. Texas Coverage is provided on Form LASD-POL-TX (05/03), Form UHCLD-POL 2/2008-TX, or UICLD-POL-TX 4/5.

UnitedHealthcare Insurance Company is located in Hartford, CT; Unimerica Insurance Company and Unimerica Life Insurance Company in Milwaukee, WI.

Henry Stark Counties Special Education District #801

Premium Calculation Sheet

Rates Effective January 1, 2024

UnitedHealthcare

Eligibility: All Active Full Time Employees working a minimum of 30 hours per week.

Employee Supplemental Life - Current Bi-Weekly Cost by Age Band

Current Monthly Rates per $1,000:	0.060	0.060	0.080	0.090	0.140	0.210	0.320	0.510	0.830	1.430	2.340	4.350
Coverage	**Age<25**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**	**70-74**	**75+**
$10,000	0.28	0.28	0.37	0.42	0.65	0.97	1.48	2.35	3.83	6.60	10.80	20.08
$20,000	0.55	0.55	0.74	0.83	1.29	1.94	2.95	4.71	7.66	13.20	21.60	40.15
$30,000	0.83	0.83	1.11	1.25	1.94	2.91	4.43	7.06	11.49	19.80	32.40	60.23
$40,000	1.11	1.11	1.48	1.66	2.58	3.88	5.91	9.42	15.32	26.40	43.20	80.31
$50,000	1.38	1.38	1.85	2.08	3.23	4.85	7.38	11.77	19.15	33.00	54.00	100.38
$60,000	1.66	1.66	2.22	2.49	3.88	5.82	8.86	14.12	22.98	39.60	64.80	120.46
$70,000	1.94	1.94	2.58	2.91	4.52	6.78	10.34	16.48	26.82	46.20	75.60	140.54
$80,000	2.22	2.22	2.95	3.32	5.17	7.75	11.82	18.83	30.65	52.80	86.40	160.62
$90,000	2.49	2.49	3.32	3.74	5.82	8.72	13.29	21.18	34.48	59.40	97.20	180.69
$100,000	2.77	2.77	3.69	4.15	6.46	9.69	14.77	23.54	38.31	66.00	108.00	200.77
$110,000	3.05	3.05	4.06	4.57	7.11	10.66	16.25	25.89	42.14	72.60	118.80	220.85
$120,000	3.32	3.32	4.43	4.98	7.75	11.63	17.72	28.25	45.97	79.20	129.60	240.92
$130,000	3.60	3.60	4.80	5.40	8.40	12.60	19.20	30.60	49.80	85.80	140.40	261.00
$140,000	3.88	3.88	5.17	5.82	9.05	13.57	20.68	32.95	53.63	92.40	151.20	281.08
$150,000	4.15	4.15	5.54	6.23	9.69	14.54	22.15	35.31	57.46	99.00	162.00	301.15
$160,000	4.43	4.43	5.91	6.65	10.34	15.51	23.63	37.66	61.29	105.60	172.80	321.23
$170,000	4.71	4.71	6.28	7.06	10.98	16.48	25.11	40.02	65.12	112.20	183.60	341.31
$180,000	4.98	4.98	6.65	7.48	11.63	17.45	26.58	42.37	68.95	118.80	194.40	361.38
$190,000	5.26	5.26	7.02	7.89	12.28	18.42	28.06	44.72	72.78	125.40	205.20	381.46
$200,000	5.54	5.54	7.38	8.31	12.92	19.38	29.54	47.08	76.62	132.00	216.00	401.54
$210,000	5.82	5.82	7.75	8.72	13.57	20.35	31.02	49.43	80.45	138.60	226.80	421.61
$220,000	6.09	6.09	8.12	9.14	14.22	21.32	32.49	51.78	84.28	145.20	237.60	441.69
$230,000	6.37	6.37	8.49	9.55	14.86	22.29	33.97	54.14	88.11	151.80	248.40	461.77
$240,000	6.65	6.65	8.86	9.97	15.51	23.26	35.45	56.49	91.94	158.40	259.20	481.85
$250,000	6.92	6.92	9.23	10.38	16.15	24.23	36.92	58.85	95.77	165.00	270.00	501.92
$260,000	7.20	7.20	9.60	10.80	16.80	25.20	38.40	61.20	99.60	171.60	280.80	522.00
$270,000	7.48	7.48	9.97	11.22	17.45	26.17	39.88	63.55	103.43	178.20	291.60	542.08
$280,000	7.75	7.75	10.34	11.63	18.09	27.14	41.35	65.91	107.26	184.80	302.40	562.15
$290,000	8.03	8.03	10.71	12.05	18.74	28.11	42.83	68.26	111.09	191.40	313.20	582.23
$300,000	8.31	8.31	11.08	12.46	19.38	29.08	44.31	70.62	114.92	198.00	324.00	602.31

To calculate the cost of coverage for an amount not shown in the table above, use the formula below:

_____	X	_____	=	_____	÷ 1,000 =	_____	X 12 ÷ 26 =	_____
Benefit Amount		Rate (See top row above)		Subtotal		Monthly Cost		Bi-Weekly Cost

Rates shown are current as of the effective date and are subject to change over time.
Costs shown are estimates only. Your actual payroll deduction may be slightly higher or lower from those provided here.
Any applicable age-related benefit reductions are <u>not</u> included.

UnitedHealthcare Life and Disability products are provided by UnitedHealthcare Insurance Company, and certain products in California by Unimerica Life Insurance Company. Texas Coverage is provided on Form LASD-POL-TX (05/03), Form UHCLD-POL 2/2008-TX, or UICLD-POL-TX 4/5.

Henry Stark Counties Special Education District #801

Premium Calculation Sheet

Rates Effective January 1, 2024

UnitedHealthcare

Spouse Supplemental Life - Current Bi-Weekly Cost by Age Band

Current Monthly Rates per $1,000:

	0.060	0.060	0.080	0.090	0.140	0.210	0.320	0.510	0.830	1.430	2.340	4.350
Coverage	**Age<25**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**	**70-74**	**75+**
$5,000	0.14	0.14	0.18	0.21	0.32	0.48	0.74	1.18	1.92	3.30	5.40	10.04
$10,000	0.28	0.28	0.37	0.42	0.65	0.97	1.48	2.35	3.83	6.60	10.80	20.08
$15,000	0.42	0.42	0.55	0.62	0.97	1.45	2.22	3.53	5.75	9.90	16.20	30.12
$20,000	0.55	0.55	0.74	0.83	1.29	1.94	2.95	4.71	7.66	13.20	21.60	40.15
$25,000	0.69	0.69	0.92	1.04	1.62	2.42	3.69	5.88	9.58	16.50	27.00	50.19
$30,000	0.83	0.83	1.11	1.25	1.94	2.91	4.43	7.06	11.49	19.80	32.40	60.23
$35,000	0.97	0.97	1.29	1.45	2.26	3.39	5.17	8.24	13.41	23.10	37.80	70.27
$40,000	1.11	1.11	1.48	1.66	2.58	3.88	5.91	9.42	15.32	26.40	43.20	80.31
$45,000	1.25	1.25	1.66	1.87	2.91	4.36	6.65	10.59	17.24	29.70	48.60	90.35
$50,000	1.38	1.38	1.85	2.08	3.23	4.85	7.38	11.77	19.15	33.00	54.00	100.38
$55,000	1.52	1.52	2.03	2.28	3.55	5.33	8.12	12.95	21.07	36.30	59.40	110.42
$60,000	1.66	1.66	2.22	2.49	3.88	5.82	8.86	14.12	22.98	39.60	64.80	120.46
$65,000	1.80	1.80	2.40	2.70	4.20	6.30	9.60	15.30	24.90	42.90	70.20	130.50
$70,000	1.94	1.94	2.58	2.91	4.52	6.78	10.34	16.48	26.82	46.20	75.60	140.54
$75,000	2.08	2.08	2.77	3.12	4.85	7.27	11.08	17.65	28.73	49.50	81.00	150.58
$80,000	2.22	2.22	2.95	3.32	5.17	7.75	11.82	18.83	30.65	52.80	86.40	160.62
$85,000	2.35	2.35	3.14	3.53	5.49	8.24	12.55	20.01	32.56	56.10	91.80	170.65
$90,000	2.49	2.49	3.32	3.74	5.82	8.72	13.29	21.18	34.48	59.40	97.20	180.69
$95,000	2.63	2.63	3.51	3.95	6.14	9.21	14.03	22.36	36.39	62.70	102.60	190.73
$100,000	2.77	2.77	3.69	4.15	6.46	9.69	14.77	23.54	38.31	66.00	108.00	200.77
$105,000	2.91	2.91	3.88	4.36	6.78	10.18	15.51	24.72	40.22	69.30	113.40	210.81
$110,000	3.05	3.05	4.06	4.57	7.11	10.66	16.25	25.89	42.14	72.60	118.80	220.85
$115,000	3.18	3.18	4.25	4.78	7.43	11.15	16.98	27.07	44.05	75.90	124.20	230.88
$120,000	3.32	3.32	4.43	4.98	7.75	11.63	17.72	28.25	45.97	79.20	129.60	240.92
$125,000	3.46	3.46	4.62	5.19	8.08	12.12	18.46	29.42	47.88	82.50	135.00	250.96
$130,000	3.60	3.60	4.80	5.40	8.40	12.60	19.20	30.60	49.80	85.80	140.40	261.00
$135,000	3.74	3.74	4.98	5.61	8.72	13.08	19.94	31.78	51.72	89.10	145.80	271.04
$140,000	3.88	3.88	5.17	5.82	9.05	13.57	20.68	32.95	53.63	92.40	151.20	281.08
$145,000	4.02	4.02	5.35	6.02	9.37	14.05	21.42	34.13	55.55	95.70	156.60	291.12
$150,000	4.15	4.15	5.54	6.23	9.69	14.54	22.15	35.31	57.46	99.00	162.00	301.15

***Spouse rate is based on Employee's age.**

To calculate the cost of coverage for an amount not shown in the table above, use the formula below:

_____	X	_____	=	_____	÷ 1,000 =	_____	X 12 ÷ 26 =	_____
Benefit Amount		Rate (See top row above)		Subtotal		Monthly Cost		Bi-Weekly Cost

Dependent Child(ren) Supplemental Life - Current Bi-Weekly Cost:

Monthly Rate per $1,000	$2,000	$4,000	$6,000	$8,000	$10,000
$0.070	0.065	0.129	0.194	0.258	0.323

Rates shown are current as of the effective date and are subject to change over time.
Costs shown are estimates only. Your actual payroll deduction may be slightly higher or lower from those provided here.
Any applicable age-related benefit reductions are <u>not</u> included.

UnitedHealthcare Life and Disability products are provided by UnitedHealthcare Insurance Company, and certain products in California by Unimerica Life Insurance Company. Texas Coverage is provided on Form LASD-POL-TX (05/03), Form UHCLD-POL 2/2008-TX, or UICLD-POL-TX 4/5.

Henry Stark Counties Special Education District #801

Premium Calculation Sheet

Rates Effective January 1, 2024

UnitedHealthcare

Employee Supplemental AD&D - Current Bi-Weekly Cost:

Current Monthly Rates per $1,000: 0.030

Coverage	*Cost*	*Coverage*	*Cost*	*Coverage*	*Cost*
$10,000	0.14	**$20,000**	0.28	**$30,000**	0.42
$40,000	0.55	**$50,000**	0.69	**$60,000**	0.83
$70,000	0.97	**$80,000**	1.11	**$90,000**	1.25
$100,000	1.38	**$110,000**	1.52	**$120,000**	1.66
$130,000	1.80	**$140,000**	1.94	**$150,000**	2.08
$160,000	2.22	**$170,000**	2.35	**$180,000**	2.49
$190,000	2.63	**$200,000**	2.77	**$210,000**	2.91
$220,000	3.05	**$230,000**	3.18	**$240,000**	3.32
$250,000	3.46	**$260,000**	3.60	**$270,000**	3.74
$280,000	3.88	**$290,000**	4.02	**$300,000**	4.15

To calculate the cost of coverage for an amount not shown in the table above, use the formula below:

_____ X 0.030 = _____ ÷ 1,000 = _____ X 12 ÷ 26 = _____

Benefit Amount | Subtotal | Monthly Cost | Bi-Weekly Cost

Spouse Supplemental AD&D - Current Bi-Weekly Cost:

Current Monthly Rates per $1,000: 0.030

Coverage	*Cost*	*Coverage*	*Cost*	*Coverage*	*Cost*
$5,000	0.07	**$10,000**	0.14	**$15,000**	0.21
$20,000	0.28	**$25,000**	0.35	**$30,000**	0.42
$35,000	0.48	**$40,000**	0.55	**$45,000**	0.62
$50,000	0.69	**$55,000**	0.76	**$60,000**	0.83
$65,000	0.90	**$70,000**	0.97	**$75,000**	1.04
$80,000	1.11	**$85,000**	1.18	**$90,000**	1.25
$95,000	1.32	**$100,000**	1.38	**$105,000**	1.45
$110,000	1.52	**$115,000**	1.59	**$120,000**	1.66
$125,000	1.73	**$130,000**	1.80	**$135,000**	1.87
$140,000	1.94	**$145,000**	2.01	**$150,000**	2.08

To calculate the cost of coverage for an amount not shown in the table above, use the formula below:

_____ X 0.030 = _____ ÷ 1,000 = _____ X 12 ÷ 26 = _____

Benefit Amount | Subtotal | Monthly Cost | Bi-Weekly Cost

Dependent Child(ren) Supplemental AD&D - Current Bi-Weekly Cost:

Monthly Rate per $1,000	**$2,000**	**$4,000**	**$6,000**	**$8,000**	**$10,000**
$0.030	0.028	0.055	0.083	0.111	0.138

Supplemental Life Insurance can be purchased without Supplemental AD&D Insurance, however you cannot purchase Supplemental AD&D Insurance without Supplemental Life Insurance. If you do elect Supplemental AD&D Insurance, the amount elected must not exceed the amount of Supplemental Life elected and approved.

This applies to you, your Spouse and your Dependent Child(ren).

Rates shown are current as of the effective date and are subject to change over time.
Costs shown are estimates only. Your actual payroll deduction may be slightly higher or lower from those provided here.
Any applicable age-related benefit reductions are <u>not</u> included.

UnitedHealthcare Life and Disability products are provided by UnitedHealthcare Insurance Company, and certain products in California by Unimerica Life Insurance Company. Texas Coverage is provided on Form LASD-POL-TX (05/03), Form UHCLD-POL 2/2008-TX, or UICLD-POL-TX 4/5.

Humana Vision 200

ILLINOIS

Vision care services	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Exam with dilation as necessary	$0	Up to $30
• Retinal imaging [1]	Up to $39	Not covered
Contact lens exam options [2]		
• Standard contact lens fit and follow-up	$0	Up to $30
• Premium contact lens fit and follow-up	10% off retail less $55 allowance	Up to $30
Frames [3]	$200 allowance 20% off balance over $200	$100 allowance
Standard plastic lenses [4]		
• Single vision	$0	Up to $25
• Bifocal	$0	Up to $40
• Trifocal	$0	Up to $60
• Lenticular	$0	Up to $100
Covered lens options [4]		
• UV coating	$15	Not covered
• Tint (solid and gradient)	$15	Not covered
• Standard scratch-resistance	$15	Not covered
• Standard polycarbonate - adults	$40	Not covered
• Standard polycarbonate - children <19	$40	Not covered
• Standard anti-reflective coating	$0	Up to $25
• Premium anti-reflective coating	Premium anti-reflective coatings as follows:	Premium anti-reflective coatings as follows:
– Tier 1	$22	Up to $25
– Tier 2	$33	Up to $25
– Tier 3	80% of charge less $35 allowance	Up to $25
• Standard progressive (add-on to bifocal)	$0	Up to $40
• Premium progressive	Premium progressives as follows:	Premium progressives as follows:
– Tier 1	$45	Up to $40
– Tier 2	$55	Up to $40
– Tier 3	$70	Up to $40
– Tier 4	$25 copay, 80% of charge less $120 allowance	Up to $40
• Photochromatic / plastic transitions	$75	Not covered
• Polarized	80% of charge	Not covered
Contact lenses [5] (applies to materials only)		
• Conventional	$200 allowance, 15% off balance over $200	$160 allowance
• Disposable	$200 allowance	$160 allowance
• Medically necessary	$0	$210 allowance

Vision care services	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Frequency		
• Examination	Once every 12 months	Once every 12 months
• Lenses or contact lenses	Once every 12 months	Once every 12 months
• Frame	Once every 24 months	Once every 24 months
Diabetic Eye Care: care and testing for diabetic members		
• Examination - Up to (2) services per year	$0	Up to $77
• Retinal Imaging - Up to (2) services per year	$0	Up to $50
• Extended Ophthalmoscopy - Up to (2) services per year	$0	Up to $15
• Gonioscopy - Up to (2) services per year	$0	Up to $15
• Scanning Laser - Up to (2) services per year	$0	Up to $33

Optional benefits

[1] Member costs may exceed $39 with certain providers. Members may contact their participating provider to determine what costs or discounts are available.
[2] Standard contact lens exam fit and follow up costs and premium contact lens exam discounts up to 10% may vary by participating provider. Members may contact their participating provider to determine what costs or discounts are available.
[3] Discounts may be available on all frames except when prohibited by the manufacturer.
[4] Lens option costs may vary by provider. Members may contact their participating provider to determine if listed costs are available.
[5] Plan covers contact lenses or frames, but not both.

Additional plan discounts

- Member may receive a 20% discount on items not covered by the plan at network Providers. Members may contact their participating provider to determine what costs or discounts are available. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Certain brand name Vision Materials may not be eligible for a discount if the manufacturer imposes a no-discount practice. Frame, Lens, & Lens Option discounts apply only when purchasing a complete pair of eyeglasses. If purchased separately, members receive 20% off the retail price.

- Members may also receive 15% off retail price or 5% off promotional price for LASIK or PRK from the US Laser Network, owned and operated by LCA Vision. Since LASIK or PRK vision correction is an elective procedure, performed by specialty trained providers, this discount may not always be available from a provider in your immediate location.

Questions?

Check out **Humana.com**
Call 1-866-995-9316 seven days a week:
8 a.m. to 6 p.m. Eastern Time
Monday through Saturday and
11 a.m. to 8 p.m. Sunday.

Humana.

Limitations and Exclusions:

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services:
   - That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
   - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
   - Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
   - War or any act of war, whether declared or not;
   - Any act of international armed conflict; or
   - Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment.
6. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
7. Prescription drugs or pre-medications, whether dispensed or prescribed.
8. Any service not specifically listed in the Schedule of Benefits.
9. Any service that we determine:
   - Is not a visual necessity;
   - Does not offer a favorable prognosis;
   - Does not have uniform professional endorsement; or
   - Is deemed to be experimental or investigational in nature.
10. Orthoptic or vision training.
11. Subnormal vision aids and associated testing.
12. Aniseikonic lenses.
13. Any service we consider cosmetic.
14. Any expense incurred before your effective date or after the date your coverage under this policy terminates.
15. Services provided by someone who ordinarily lives in your home or who is a family member.
16. Charges exceeding the reimbursement limit for the service.
17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
18. Plano lenses.
19. Medical or surgical treatment of eye, eyes, or supporting structures.
20. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
21. Any examination or material required by an Employer as a condition of employment.
22. Non-prescription sunglasses.
23. Two pair of glasses in lieu of bifocals.
24. Services or materials provided by any other group benefit plans providing vision care.
25. Certain name brands when manufacturer imposes no discount.
26. Corrective vision treatment of an experimental nature.
27. Solutions and/or cleaning products for glasses or contact lenses.
28. Pathological treatment.
29. Non-prescription items.
30. Costs associated with securing materials.
31. Pre- and Post-operative services.
32. Orthokeratology.
33. Routine maintenance of materials.
34. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the certificate.
35. Artistically painted lenses.

Humana Vision products insured by Humana Insurance Company, Humana Health Benefit Plan of Louisiana, The Dental Concern, Inc. or Humana Insurance Company of New York. In Arizona, group vision plans insured by Humana Insurance Company. In New Mexico, group vision plans insured by Humana Insurance Company.

This is not a complete disclosure of the plan qualifications and limitations. Specific limitations and exclusions as contained in the Regulatory and Technical Information Guide will be provided by the agent. Please review this information before applying for coverage.

NOTICE: Your actual expenses for covered services may exceed the stated cost or reimbursement amount because actual provider charges may not be used to determine insurer and member payment obligations.

Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status, or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call **1-877-320-1235** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.
- **California residents**: You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。
Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .
Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.
Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
日本語 **(Japanese):** 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。
فارسی (Farsi)
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.
Diné Bizaad (Navajo): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę niká'adoowoł.
العربية (Arabic)
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

GCHJV5REN 0220

UnitedHealthcare Insurance Company® Dental Plan
Contributory Options PPO 30 / covered dental services 5P478/U90

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Deductible	$50	$50	$0	$0
Family Annual Deductible	$150	$150	$0	$0
Maximum (the sum of all Network and Non-Network benefits will not exceed Annual maximum)	$5,000 per person per Calendar Year	$5,000 per person per Calendar Year	$2,000 per person per Lifetime	$2,000 per person per Lifetime
New enrollee's waiting period	None			
Annual deductible applies to preventive and diagnostic services			No (In Network)	No (Out Network)
Annual Deductible Applies to Orthodontic Services			No	
Orthodontic Eligibility Requirement			Child Only (Up to Age 19)	

COVERED SERVICES *	NETWORK PLAN PAYS**	NON-NETWORK PLAN PAYS***	BENEFIT GUIDELINES
DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	100%	See Exclusions and Limitations section for benefit guidelines.
Radiographs	100%	100%	
Lab and Other Diagnostic Tests	100%	100%	
PREVENTIVE SERVICES			
Prophylaxis (Cleaning)	100%	100%	See Exclusions and Limitations section for benefit guidelines.
Fluoride Treatment (Preventive)	100%	100%	
Sealants	100%	100%	
Space Maintainers	100%	100%	
BASIC SERVICES			
Restorations (Amalgams or Composite)	80%	80%	See Exclusions and Limitations section for benefit guidelines.
Emergency Treatment/General Services	80%	80%	
Simple Extractions	80%	80%	
Oral Surgery (incl. surgical extractions)	80%	80%	
Periodontics	80%	80%	
Endodontics	80%	80%	
MAJOR SERVICES			
Inlays/Onlays/Crowns	50%	50%	See Exclusions and Limitations section for benefit guidelines.
Dentures and Removable Prosthetics	50%	50%	
Fixed Partial Dentures (Bridges)	50%	50%	
ORTHODONTIC SERVICES			
Diagnose or correct misalignment of the teeth or bite	50%	50%	

* Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over $500; please consult your dentist.

**The network percentage of benefits is based on the discounted fees negotiated with the provider.

***The non-network percentage of benefits is based on the usual and customary fees in the geographic areas in which the expenses are incurred.

Veneers are only covered when a filling cannot restore a tooth. For a complete description and coverage levels for Veneers, please refer to your Certificate of Coverage. Cone Beams are limited to combined captured and interpretation treatment codes only. For a complete description and coverage levels for Cone Beams, please refer to your Certificate of Coverage.

In accordance with the Illinois state requirement, a partner in a Civil Union is included in the definition of Dependent. For a complete description of Dependent Coverage, please refer to your Certificate of Coverage.

The Prenatal Dental Care (not available in WA) and Oral Cancer Screening programs are covered under this plan.

The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above table provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

UnitedHealthcare Dental Options PPO Plan is either underwritten or provided by: United HealthCare Insurance Company, Hartford, Connecticut; United HealthCare Insurance Company of New York, Hauppauge, New York; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York or United HealthCare Services, Inc.

UnitedHealthcare/Dental Exclusions and Limitations

Dental Services described in this section are covered when such services are:

A. Necessary;

B. Provided by or under the direction of a Dentist or other appropriate provider as specifically described;

C. The least costly, clinically accepted treatment, and

D. Not excluded as described in the Section entitled. General Exclusions.

GENERAL LIMITATIONS

1 PERIODIC ORAL EVALUATION Limited to 2 times per consecutive 12 months.

2 COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to 1 time per consecutive 36 months.

3 BITEWING RADIOGRAPHS Limited to 1 series of films per calendar year.

4 EXTRAORAL RADIOGRAPHS Limited to 2 films per calendar year.

5 DENTAL PROPHYLAXIS Limited to 2 times per consecutive 12 months.

6 FLUORIDE TREATMENTS Limited to covered persons under the age of 16 years, and limited to 2 times per consecutive 12 months.

7 SPACE MAINTAINERS Limited to covered persons under the age of 16 years, limited to 1 per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.

8 SEALANTS Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months.

9 RESTORATIONS (Amalgam or Composite) Multiple restorations on one surface will be treated as a single filling.

10 PIN RETENTION Limited to 2 pins per tooth; not covered in addition to cast restoration.

11 INLAYS, ONLAYS, AND VENEERS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

12 CROWNS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.

13 POST AND CORES Covered only for teeth that have had root canal therapy.

14 SEDATIVE FILLINGS Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.

15 SCALING AND ROOT PLANING Limited to 1 time per quadrant per consecutive 24 months.

16 ROOT CANAL THERAPY Limited to 1 time per tooth per lifetime.

17 PERIODONTAL MAINTENANCE Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.

18 FULL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

19 PARTIAL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.

20 RELINING AND REBASING DENTURES Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.

21 REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.

22 PALLIATIVE TREATMENT Covered as a separate benefit only if no other service, other than the exam and radiographs, were performed on the same tooth during the visit.

23 OCCLUSAL GUARDS Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.

24 FULL MOUTH DEBRIDEMENT Limited to 1 time every consecutive 36 months.

25 GENERAL ANESTHESIA Covered only when clinically necessary.

26 OSSEOUS GRAFTS Limited to 1 per quadrant or site per consecutive 36 months.

27 PERIODONTAL SURGERY Hard tissue and soft tissue periodontal surgery are limited to 1 quadrant or site per consecutive 36 months per surgical area.

28 REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.

29 CONE BEAM Limited to 1 time per consecutive 60 months.

GENERAL EXCLUSIONS

The following are not covered:

1 Dental Services that are not Necessary.

2 Hospitalization or other facility charges.

3 Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)

4 Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.

5 Any Dental Procedure not directly associated with dental disease.

6 Any Dental Procedure not performed in a dental setting.

7 Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

8 Placement of dental implants, implant-supported abutments and prostheses.

9 Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.

10 Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.

11 Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.

12 Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.

13 Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.

14 Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.

15 Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.

16 Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.

17 Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.

18 Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).

19 Occlusal guards used as safety items or to affect performance primarily in sports-related activities.

20 Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

21 Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child. This exclusion does not apply for groups sitused in the state of Arizona, in order to comply with state regulations.

22 Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.

23 Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

24 Orthodontic service Coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, or a surgical procedure to correct a malocclusion, replacement of retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.

25 Foreign Services are not Covered unless required as an Emergency.

26 Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

27 Services for injuries or conditions covered by Worker’s Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.

2024
PLAN COMPARISON
HENRY-STARK COUNTIES S.E.D.

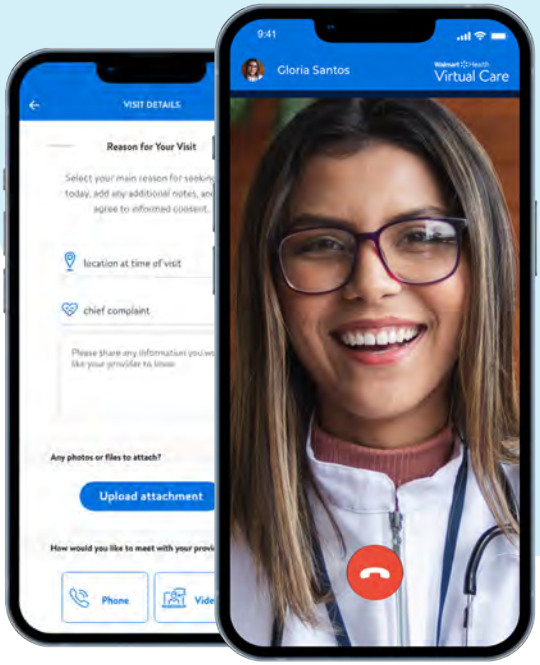
COVERED ITEM	PARETO SCA PPO	PARETO AETNA PPO	PARETO OUT OF PPO	COVERED ITEM
PPO PLAN				
PPO	**Springfield Clinic**	**Aetna Network**	**Out Of Network**	**PPO**
Network	**Renewal Tier 1**	**Renewal Tier 2**	**Out Of Network**	**Network**
Ind. Deductible	$750	$1,500	$7,000	**Ind. Deductible**
Family Deductible	$1,500	$3,000	$21,000	**Family Deductible**
Coinsurance Reimbursement	90% $10,000	80% $10,000	60% $12,000	**Coinsurance Reimbursement**
	Includes Deductible	**Includes Deductible**	**Includes Deductible**	
Out of Pocket	**Rx & Dr. CoPay**	**Rx & Dr. CoPay**	**Rx & Dr. CoPay**	**Out of Pocket**
Individual	$1,750	$3,500	$11,800	**Individual**
Family	$3,500	$7,000	$23,600	**Family**
Emergency	$500 CoPay	$500 CoPay	$500 CoPay	**Emergency**
Wellness Care	100% No Deductible	100% No Deductible	Deductible – 60%	**Wellness Care**
Quest Labs	Included	Included	Included	**Quest Labs**
Physician CoPay	$0 CoPay	$30 CoPay	Deductible – 60%	**Physician CoPay**
Virtual Visits	Included	Included	Included	**Virtual Visits**
Specialist CoPay	$0 CoPay	$50 CoPay	Deductible – 60%	**Specialist CoPay**
Urgent Copay	$25 CoPay	$75 CoPay	Deductible – 60%	**Urgent Copay**
SmithRx	Included	Included	Included	**SmithRx**
Mark Cuban				**Mark Cuban**
Cost Plus Plan	Included	Included	Included	**Cost Plus Plan**
Rx Card				Rx Card
Generic Drugs	$10 CoPay	$10 CoPay	$10 CoPay	Generic Drugs
Preferred Brand	$40 CoPay	$40 CoPay	$40 CoPay	Preferred Brand
Non-Preferred Brand	$60 CoPay	$60 CoPay	$60 CoPay	Non-Preferred Brand
Specialty	$150 CoPay	$150 CoPay	$150 CoPay	Specialty

2024
PLAN COMPARISON
HENRY-STARK COUNTIES S.E.D.

COVERED ITEM	PARETO SCA PPO	PARETO AETNA PPO	PARETO OUT OF PPO	COVERED ITEM
HSA PLAN				
PPO	**Springfield Clinic**	**Aetna Network**	**Out Of Network**	**PPO**
Network	**Renewal Tier 1**	**Renewal Tier 2**	**Out Of Network**	**Network**
Ind. Deductible	$3,200	$3,840	$5,400	**Ind. Deductible**
Family Deductible	$6,400	$7,680	$10,800	**Family Deductible**
Coinsurance **Reimbursement**	100% N/A	80% $800	80% $26,000	**Coinsurance** **Reimbursement**
Out of Pocket	**Includes Deductible**	**Includes Deductible**	**Includes Deductible**	**Out of Pocket**
Individual	$3,200	$4,000	$10,600	**Individual**
Family	$6,400	$8,000	$21,200	**Family**
Emergency	Deductible – 100%	Deductible – 80%	Deductible – 80%	**Emergency**
Wellness Care	100% No Deductible	100% No Deductible	100% No Deductible	**Wellness Care**
Quest Labs	Included	Included	Included	**Quest Labs**
Physician CoPay	Deductible – 100%	Deductible – 80%	Deductible – 80%	**Physician CoPay**
Virtual Visits	Included	Included	Included	**Virtual Visits**
Specialist CoPay	Deductible – 100%	Deductible – 80%	Deductible – 80%	**Specialist CoPay**
Urgent Copay	Deductible – 100%	Deductible – 80%	Deductible – 80%	**Urgent Copay**
SmithRx	Included	Included	Included	**SmithRx**
Mark Cuban				**Mark Cuban**
Cost Plus Plan	Included	Included	Included	**Cost Plus Plan**
Rx Card				**Rx Card**
Generic Drugs	Deductible – 100%	Deductible – 80%	Deductible – 80%	Generic Drugs
Preferred Brand	Deductible – 100%	Deductible – 80%	Deductible – 80%	Preferred Brand
Non-Preferred Brand	Deductible – 100%	Deductible – 80%	Deductible – 80%	Non-Preferred Brand
Specialty	Deductible – 100%	Deductible – 80%	Deductible – 80%	Specialty

Walmart Health
Virtual Care

Convenient, affordable telehealth for you & your family!



We are pleased to announce that you and your family now have access to Walmart Health Virtual Care – your new telehealth service. Telehealth allows you to reach a medical provider for a virtual visit when access to your regular doctor is not available, 24/7/365.

What is telehealth?

Telehealth utilizes technology to give you and your family affordable and convenient access to medical services online. Using Walmart Health Virtual Care's telehealth service and national team of US-licensed, board-certified medical providers, you can connect with a provider online to receive care and a personalized treatment plan, including prescriptions when medically necessary. Telehealth can help when you need medical attention after-hours, when your regular doctor is not available, or when travel is difficult; it does not replace seeing a doctor in-person for your annual office visit.

How does Virtual Care work?

When you have a health issue, either call Walmart Health Virtual Care (WHVC) or visit the website listed below. After you've created your account it's simple to request a real-time consultation with one of WHVC's medical providers. Your provider will review your medical history and perform a video or phone (where permitted) visit within minutes. You will then receive a visit summary and care instructions electronically, with any necessary prescriptions sent to your local pharmacy for pick-up. If you require urgent care you will be immediately referred to the nearest emergency room or urgent care center. The entire telehealth visit is completed on average within 30 minutes or less.

What medical conditions can Virtual Care address?

Below is a sample of medical conditions that WHVC providers can evaluate:

- Abrasions, bruises
- Colds, flu and fever
- Sore throat, cough, congestion
- Allergies, hives, skin infections
- Bites and stings
- Minor headaches, arthritic pains
- Medication refills*
- Diarrhea, vomiting, nausea
- Urinary tract infections
- Headaches, body aches
- Eye infections, conjunctivitis

And more!

**When medically necessary, providers may prescribe medication that patient can pick up at a local pharmacy. Prescriptions cannot be written for controlled substances.*

Feel better faster: wmthealth.com/consociate

Q Who is eligible to use the service?

The program is available to you, your spouse or domestic partner, and children up to the age of 26.

Q Does Virtual Care take the place of a primary doctor or specialist?

No. The WHVC urgent care telehealth program is designed to supplement care when your regular doctor is not available. For example, in the evening, on holidays and weekends, or when you cannot get an appointment or connect with your regular provider. A primary care doctor or specialist is still the best choice for ongoing treatment and care.

Q Will I see a quality provider?

Yes. Care is provided by our medical team of US-licensed, board-certified physicians, nurse practitioners and physician assistants who practice in healthcare facilities across the United States.

Q Do I need an email address?

Yes. An email address is required in order to create a profile.

Q Is this service confidential?

Yes. WHVC services are HIPAA compliant and completely confidential.

Q Is a webcam required?

Yes, in most cases. Many ailments can be treated via an audio-only visit, though we highly encourage video visits when feasible, since it allows our providers to better assess your condition and deliver the best possible care. A video visit may be required in certain states. Please contact WHVC for further information.

Q How much does the service cost?

WHVC is being offered to you at a special discounted rate of $0 for each virtual visit.

Next steps:

1. **Sign in**
   Visit your WHVC website to sign up/activate your virtual care account.
   Visit: **wmthealth.com/consociate**
   Enter member ID: **Consociate Member ID**

2. **Request a virtual visit**
   For non-emergency health concerns, you can request a visit using your phone, tablet or computer – 24/7/365.

3. **Speak with a provider**
   Meet with your virtual care medical provider who will asses your symptoms, recommend treatment and prescribe medication if medically appropriate.

QuestSelect™ Advanced lab benefit

Control the cost of your healthcare

QuestSelect™ Advanced is a value-added health benefit that can help save you money on outpatient laboratory testing. When you show your healthcare provider your QuestSelect card to obtain outpatient testing, there is no cost to you—testing will be covered by your employer or medical plan. There are no copays, no deductibles, and no coinsurance.*

For a current listing of collection sites visit QuestSelect.com. On the website you can also:

- Print a QuestSelect card
- Read instructions on how to use your QuestSelect benefit
- Find resources you can share with your healthcare provider

To receive the benefits of the QuestSelect Advanced program, you must present your QuestSelect card or healthcare ID card with the QuestSelect logo on it at the time of each service, and request your provider send your laboratory testing order to Quest Diagnostics.

The QuestSelect laboratory benefit covers routine outpatient testing. It does NOT cover:

- Testing ordered during hospitalization
- Lab work needed on an emergency or (STAT) basis
- Testing done at another laboratory
- Time-sensitive esoteric testing such as fertility testing, bone marrow studies and spinal fluid tests

The QuestSelect program is completely voluntary and provides you with 100% coverage for your covered outpatient laboratory testing. If you and/or your healthcare provider choose to send testing to any laboratory other than Quest Diagnostics, the QuestSelect benefit will not apply.

Saving with QuestSelect™ is simple

1. At your appointment, show your QuestSelect card and ask for your lab work to be sent to Quest.

2. If the office doesn't use Quest for testing, you can ask your provider to call the QuestSelect Lab Line to request a pickup. Or you can ask your provider for a written order to have your lab work collected at an approved Quest Patient Service Center (PSC) location.

3. The sample is collected at the healthcare provider's office or PSC and is sent to Quest Diagnostics for processing.

4. Testing is completed by Quest and results are sent to your provider. You can also access your results through MyQuest™ online.

For more information about your QuestSelect Advanced laboratory benefit, visit QuestSelect.com or call 1.800.646.7788 today.

*Provider collection and handling fees may apply and are subject to health benefit plan provisions.

QuestSelect™ Plus lab benefit

Control the cost of your healthcare

QuestSelect™ Plus is a value-added health benefit that can help save you money on outpatient laboratory testing. Show your healthcare provider your QuestSelect card to obtain outpatient testing at a reduced out-of-pocket cost.

For a current listing of collection sites visit QuestSelect.com. On the website you can also:

- Print a QuestSelect card
- Read instructions on how to use your QuestSelect benefit
- Find resources you can share with your healthcare provider

To receive the benefits of the QuestSelect Plus program, you must present your QuestSelect card or healthcare ID card with the QuestSelect logo on it at the time of each service, and request your provider send your laboratory testing order to Quest Diagnostics.

The QuestSelect Plus laboratory benefit covers routine outpatient testing. It does NOT cover:

- Testing ordered during hospitalization
- Lab work needed on an emergency basis
- Testing done at another laboratory
- Time-sensitive esoteric testing such as fertility testing, bone marrow studies, and spinal fluid tests

The QuestSelect program is completely voluntary and provides you with significant savings for your covered outpatient laboratory testing. If you and/or your healthcare provider choose to send testing to any laboratory other than Quest Diagnostics, the QuestSelect benefit will not apply.

Saving with QuestSelect™ is simple

1. At your appointment, show your QuestSelect card and ask for your lab work to be sent to Quest.

2. If the office doesn't use Quest for testing, you can ask your provider to call the QuestSelect Lab Line to request a pickup. Or you can ask your provider for a written order to have your lab work collected at an approved Quest Patient Service Center (PSC) location.

3. The sample is collected at the healthcare provider's office or PSC and is sent to Quest Diagnostics for processing.

4. Testing is completed by Quest and results are sent to your provider. You can also access your results through MyQuest™ online.

For more information about your QuestSelect Plus laboratory benefit, visit QuestSelect.com or call 1.800.646.7788 today.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, see your Human Resources Department. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.consociatehealth.com or call 1-800-798-2422 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1 - Springfield Clinic Advantage, BJC COE: $750 Person / $1,500 Family Tier 2 - Aetna: $1,500 Person / $3,000 Family Tier 3 - Out-of-Network: $7,000 Person / $21,000 Family	Generally, you must pay all of the costs from providers up to the calendar year deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Tier 1 - Springfield Clinic Advantage, BJC COE: $1,750 Person / $3,500 Family Tier 2 - Aetna: $3,500 Person / $7,000 Family Tier 3 - Out-of-Network: $11,800 Person / $23,600 Family	The out-of-pocket limit is the most you could pay in a calendar year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, copayments, penalties for failure to obtain preauthorization, ineligible charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.consociatehealth.com or call 1-800-798-2422 for a list of network providers	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No. You do not need a referral to see a specialist.	A referral is not required to see a specialist for covered services.

Important Questions	Answers	Why This Matters:

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1: SCA, BJC COE (You will pay the least)	Tier 2: Aetna	Tier 3: Out of Network (You will pay the most)	
If you visit a health care **provider's** office or clinic	Primary care visit to treat an injury or illness	$0 copayment	$30 copayment	40% coinsurance	Virtual visit covered as any other office visit. Telehealth available for $0 copayment at wmthealth.com/patient.
	Specialist visit	$0 copayment	$50 copayment	40% coinsurance	
	Preventive care/screening/ immunization	Covered 100%, deductible does not apply	Covered 100%, deductible does not apply	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	40% coinsurance	Preauthorization is required for some high-tech imaging.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.smithrx.com, or call 1-844-454-5201		Participating Pharmacies	Non-Participating Pharmacies		
	Generic drugs	30-day: $10 copayment 90-day: $20 copayment	Not Covered		Deductible does not apply. 30-day supply (retail) 90-day supply (retail or mail order)
	Preferred brand drugs	30-day: $40 copayment 90-day: $80 copayment			
	Non-preferred brand drugs	30-day: $60 copayment 90-day: $120 copayment			
	Specialty drugs	$150 copayment	Not Covered		Please see Prescription Drug Benefit section in Plan Document for details. Prior Authorization may be required. Specialty limited to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	10% coinsurance	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$500 copayment per visit, deductible does not apply			Preauthorization is required if admitted to Hospital from ER. Copay is NOT waived if admitted.
	Emergency medical transportation	10% coinsurance	20% coinsurance	40% coinsurance	None
	Urgent care	$25 copayment	$75 copayment	40% coinsurance	None

[* For more information about limitations and exceptions, see the plan or policy document at www.consociatehealth.com

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1: SCA, BJC COE (You will pay the least)	Tier 2: Aetna	Tier 3: Out of Network (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	$300 copayment per visit, then 40% coinsurance	Preauthorization is required.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Office Visit	$0 copayment	$30 copayment	40% coinsurance	Virtual visit covered as any other office visit.
	Outpatient services	10% coinsurance	20% coinsurance	40% coinsurance	
	Inpatient services	10% coinsurance	20% coinsurance	$300 copayment per visit, then 40% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	$0 copayment	$30 copayment	40% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound) for employee or spouse only. Preauthorization is required for some maternity hospital stays.
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	$300 copayment per visit, then 40% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	40% coinsurance	Preauthorization is required.
	Rehabilitation services	10% coinsurance	20% coinsurance	40% coinsurance	None
	Habilitation services	10% coinsurance	20% coinsurance	40% coinsurance	None
	Skilled nursing care	10% coinsurance	20% coinsurance	$300 copayment per visit, then 40% coinsurance	Preauthorization is required.
	Durable medical equipment	10% coinsurance	20% coinsurance	40% coinsurance	Preauthorization required. Benefits limited to items used for a medical purpose. DME benefits provided for both purchase and rental equipment (up to the purchase price).
	Hospice services	10% coinsurance	20% coinsurance	40% coinsurance	Preauthorization is required if inpatient services. Additional $300 copayment per visit applies for Tier 3 inpatient services.
If your child needs dental or eye care	Children's eye exam	Not Covered			None
	Children's glasses	Not Covered			None
	Children's dental check-up	Not Covered			None

[* For more information about limitations and exceptions, see the plan or policy document at www.consociatehealth.com

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • Cosmetic surgery • Dental care (Adult)	• Long-term care • Routine foot care, except for diabetes	• Routine eye care (Adult) • Non-emergency care when outside the U.S.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric Surgery (subject to medical management criteria) • Chiropractic Care (limited to 30 visits per calendar year). Naprapathic Services (limited to 15 visits per calendar year).	• Hearing Aids (No limit if under age 18. For 18 and above, limited to one hearing aid per ear every 36 months up to $2,500 per ear).	• Infertility treatment (limited to $10,000 per lifetime for prescriptions, and an additional $25,000 for infertility treatment). • Private-duty nursing (with the exception of inpatient private-duty nursing).

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Consociate Health: 1-800-798-2422. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Consociate Health: 1-800-798-2422.

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-798-2422

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-798-2422

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-798-2422

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-798-2422

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

[* For more information about limitations and exceptions, see the plan or policy document at www.consociatehealth.com

About these Coverage Examples:

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

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

- The **plan's** overall deductible $1,500
- Specialist copayment $0
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$3,500

Managing Joe's Type 2 Diabetes
(a year of routine Aetna-network care of a well-controlled condition)

- The **plan's** overall deductible $1,500
- Specialist copayment $30
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$500
Coinsurance	$720
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$2,720

Mia's Simple Fracture
emergency room visit and follow up care at Aetna-network)

- The **plan's** overall deductible $1,500
- Specialist & ER copayment $530
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$530
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,030

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, see your Human Resources Department. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.consociatehealth.com or call 1-800-798-2422 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1 - Springfield Clinic Advantage, BJC COE: $3,200 Person / $6,400 Family Tier 2 - Aetna: $3,840 Person / $7,680 Family Tier 3 - Out-of-Network: $5,400 Person / $10,800 Family	Generally, you must pay all of the costs from providers up to the calendar year deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Tier 1 - Springfield Clinic Advantage, BJC COE: $3,200 Person / $6,400 Family Tier 2 - Aetna: $4,000 Person / $8,000 Family Tier 3 - Out-of-Network: $10,600 Person / $21,200 Family	The out-of-pocket limit is the most you could pay in a calendar year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, copayments, penalties for failure to obtain preauthorization, ineligible charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.consociatehealth.com or call 1-800-798-2422 for a list of network providers	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No. You do not need a referral to see a specialist.	A referral is not required to see a specialist for covered services.

Important Questions	Answers	Why This Matters:

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1: SCA, BJC COE (You will pay the least)	Tier 2: Aetna	Tier 3: Out of Network (You will pay the most)	
If you visit a health care **provider's** office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	20% coinsurance	20% coinsurance	Virtual visit covered as any other office visit. Telehealth available at wmthealth.com/patient.
	Specialist visit	0% coinsurance	20% coinsurance	20% coinsurance	
	Preventive care/screening/ immunization	Covered 100%, deductible does not apply	Covered 100%, deductible does not apply	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	20% coinsurance	20% coinsurance	
	Imaging (CT/PET scans, MRIs)	0% coinsurance	20% coinsurance	20% coinsurance	Preauthorization is required for some high-tech imaging.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.smithrx.com, or call 1-844-454-5201		Participating Pharmacies	Non-Participating Pharmacies		
	Generic drugs	0% coinsurance	Not Covered		30-day supply (retail) 90-day supply (retail or mail order)
	Preferred brand drugs	0% coinsurance			
	Non-preferred brand drugs	0% coinsurance			
	Specialty drugs	0% coinsurance	Not Covered		Please see Prescription Drug Benefit section in Plan Document for details. Prior Authorization may be required. Specialty limited to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	20% coinsurance	20% coinsurance	None
	Physician/surgeon fees	0% coinsurance	20% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room care	0% coinsurance after Tier 2 deductible. If at SCA or BJC, Tier 1 deductible applies.			Preauthorization is required if admitted to Hospital from ER.
	Emergency medical transportation	0% coinsurance	20% coinsurance	20% coinsurance	None
	Urgent care	0% coinsurance	20% coinsurance	20% coinsurance	None

[* For more information about limitations and exceptions, see the plan or policy document at www.consociatehealth.com

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1: SCA, BJC COE (You will pay the least)	Tier 2: Aetna	Tier 3: Out of Network (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance:	20% coinsurance	$300 copayment per visit, then 20% coinsurance	Preauthorization is required.
	Physician/surgeon fees	0% coinsurance	20% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Office Visit	0% coinsurance	20% coinsurance	20% coinsurance	Virtual visit covered as any other office visit.
	Outpatient services	0% coinsurance	20% coinsurance	20% coinsurance	
	Inpatient services	0% coinsurance	20% coinsurance	$300 copayment per visit, then 20% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	0% coinsurance	20% coinsurance	20% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) employee or spouse only. Preauthorization is required for some maternity hospital stays. Plan allows out-of-network/over the counter breast pumps up to $300 per pregnancy at 100%.
	Childbirth/delivery professional services	0% coinsurance	20% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	20% coinsurance	$300 copayment per visit, then 20% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	20% coinsurance	20% coinsurance	Preauthorization is required.
	Rehabilitation services	0% coinsurance	20% coinsurance	20% coinsurance	None
	Habilitation services	0% coinsurance	20% coinsurance	20% coinsurance	None
	Skilled nursing care	0% coinsurance	20% coinsurance	$300 copayment per visit, then 20% coinsurance	Preauthorization is required.
	Durable medical equipment	0% coinsurance	20% coinsurance	20% coinsurance	Preauthorization required. Benefits limited to items used for a medical purpose. DME benefits provided for both purchase and rental equipment (up to the purchase price).
	Hospice services	0% coinsurance	20% coinsurance	20% coinsurance	Preauthorization is required if inpatient services. Additional $300 copayment per visit applies for Tier 3 inpatient services.
If your child needs dental or eye care	Children's eye exam	Not Covered			None
	Children's glasses	Not Covered			None
	Children's dental check-up	Not Covered			None

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Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • Cosmetic surgery • Dental care (Adult)	• Long-term care • Routine foot care, except for diabetes	• Routine eye care (Adult) • Non-emergency care when outside the U.S.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric Surgery (subject to medical management criteria) • Chiropractic Care (limited to 30 visits per calendar year). Naprapathic Services (limited to 15 visits per calendar year).	• Hearing Aids (No limit if under age 18. For 18 and above, limited to one hearing aid per ear every 36 months up to $2,500 per ear).	• Infertility treatment (limited to $10,000 per lifetime for prescriptions, and an additional $25,000 for infertility treatment). • Private-duty nursing (with the exception of inpatient private-duty nursing).

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Does this plan provide Minimum Essential Coverage? Yes

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Does this plan meet the Minimum Value Standards? Yes

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

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[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-798-2422

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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About these Coverage Examples:

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

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

The **plan's** overall deductible	$3,840
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,840
Copayments	$0
Coinsurance	$160
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$4,000

Managing Joe's Type 2 Diabetes
(a year of routine Aetna-network care of a well- controlled condition)

The **plan's** overall deductible	$3,840
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,840
Copayments	$0
Coinsurance	$160
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$4,000

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

The **plan's** overall deductible	$3,840
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,800

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

2024 HSA AND HDHP LIMITS

Each year, the IRS announces inflation-adjusted limits for health savings accounts (HSAs) and high deductible health plans (HDHPs).

The following chart shows the HSA and HDHP limits for 2024 as compared to 2023. It also includes the catch-up contribution limit that applies to HSA-eligible individuals who are age 55 or older, which is not adjusted for inflation and stays the same from year to year.

TYPE OF LIMIT		2023	2024	CHANGE
HSA Contribution Limit	Self-only	$3,850	$4,150	**Up $300**
	Family	$7,750	$8,300	**Up $550**
HSA Catch-up Contributions *(not subject to adjustment for inflation)*	Age 55 or older	$1,000	$1,000	No change
HDHP Minimum Deductible	Self-only	$1,500	$1,600	**Up $100**
	Family	$3,000	$3,200	**Up $200**
HDHP Maximum Out-of-Pocket Expense Limit *(deductibles, copayments and other amounts, but not premiums)*	Self-only	$7,500	$8,050	**Up $550**
	Family	$15,000	$16,100	**Up $1,100**

CONSOCIATE HEALTH

IMPORTANT NOTICES:
REGARDING OUR CONSOCIATE BENEFIT PLAN FOR
HENRY STARK COUNTIES SPECIAL EDUCATION DISTRICT

The following notices provide important information about the group health plan provided by your employer. Please read the attached notices carefully and keep a copy for your records.

If you have any questions regarding any of these notices, please contact:

General Contact: Jennifer Harker
Phone: 309-852-5696
Email: jharker@hsced.org
Mailing Address: 1318 W 6th Street, Kewanee, IL 61443

Plan Administrator: Jennifer Harker
Phone: 309-852-5696
Email: jharker@hsced.org
Mailing Address: 1318 W 6th Street, Kewanee, IL 61443

Distribution Date: 12/01/2023

These notices are available free of charge, upon request to the Plan Administrator.

Please note this is not a legal document and should not be construed as legal advice.

Women's Health and Cancer Rights Act 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 309-852-5696.

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.
If you would like more information on WHCRA benefits, call your Plan Administrator at 309-852-5696.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours.) Refer to your plan document for specific information about childbirth coverage or contact your Plan Administrator at 309-852-5696.

Mental Health Parity and Addition Equity Act (MHPA/MHPAEA)

Mental Health Parity and Addition Equity Act (MHPA/MHPAEA) requires that group health plans not unfairly restrict treatment with regards to benefits/services applicable to mental health or substance use disorders. Additional information and details can be found by visiting the Department of Labor's Mental Health Parity webpage located at http://www.dol/gov/ebsa/newsroom/fsmhpaea.html.

Family Medical Leave Act (FMLA)

Family Medical Leave Act (FMLA) entitles eligible employees of covered employers to take unpaid, job-protected leave for specific family and medical reasons if the employee has been with the company for one year, has worked at least 1250 hours during the prior 12 months and works in an area where there are at least 50 employees within 75 miles. For additional details, visit the Department of Labor FMLA page. Notify the organization when you have a qualifying leave such as birth or adoption of a child, a serious health condition, to care for a spouse, child or parent with a serious medical condition or for reservist or National Guard provisions related to you or an immediate family member leaving for military duty or being injured in active duty.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA-Medicaid	**CALIFORNIA-Medicaid**
Website: http://myalhipp.com Phone: 1-855-692-5447	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://health.alaska.gov/dpa/pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIB Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA-Medicaid	**MASSACHUSETTS-Medicaid and CHIP**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid/georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102 Email: masspremassistance@accenture.com

INDIANA-Medicaid	MINNESOTA-Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid Phone 1-800-457-4584	Website: http://mn.gove/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp https://mn.gov/dhs/people-we-serve/children-and families/health-care/health-care-programs/programs-and-All other Medicaid services/other-insurance.isp Phone: 1-800-657-3739
IOWA-Medicaid and CHIP (Hawki)	**MISSOURI-Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS-Medicaid	**MONTANA-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY-Medicaid	**NEBRASKA-Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA-Medicaid	**NEVADA-Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE-Medicaid	**NEW HAMPSHIRE-Medicaid**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY-Medicaid and CHIP	**SOUTH DAKOTA-Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059

NEW YORK-Medicaid	**TEXAS-Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA-Medicaid	**VERMONT-Medicaid**
Website: https://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://dvha.vermont.gov/members/medicaid/hipp-program Phone: 1-800-250-8427
OKLAHOMA-Medicaid and CHIP	**WISCONSIN-Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.dhs.wisconsin.gov/badgercareplus/p=10095.htm Phone: 1-800-362-3002
OREGON-Medicaid	**WASHINGTON-Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA-Medicaid and CHIP	**WEST VIRGINIA-Medicaid**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://dhhr.wv.gov/bms Medicaid phone: 304-558-1700
RHODE ISLAND-Medicaid and CHIP	**WEST VIRGINIA- CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH CAROLINA-Medicaid	**WYOMING-Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31st, 2023, or for more information on special enrollment rights, contact either:

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

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

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

You are protected from balance billing for:

Emergency services

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

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

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

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

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

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact https://www.cms.gov/nosurprises/help-resolve-payment-disputes/payment-disputes-between-providers-and-health-plans

Transparency In Coverage Shopping Tools

Under the No Surprises Act, health plans will be required to disclose personalized price and cost-sharing information to plan participants, beneficiaries and enrollees. Specifically, plans must provide personalized out-of-pocket cost information and underlying negotiated rates for all covered health care items and services, including prescription drugs, through an internet-based self-service tool and in paper form upon request.

An initial list of 500 shoppable services is required to be available on the self-service tool, for plan years that begin on or after January 1, 2023. A list of the remainder of all items and services will be required for these self-service tools for plan years that begin on or after January 1, 2024.

Your Insurance Company has posted the initial listing on the member login page. You are able to access this information by visiting the home page.

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 four 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, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0123.

Wellness Program – Notice of Reasonable Alternatives

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact Human Resources and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.''

Patient Protection Notice

Consociate generally does not 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.

HIPAA Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

If not attached to this document, you may request a copy of the current Privacy Practices, explaining how medical information about you may be used and disclosed and how you can get access to this information.
As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

You have the right to inspect and copy, right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

Notice of Special Enrollment Rights

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

If you are declining enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within 60 days after you or your dependents become eligible for the premium assistance.

To request special enrollment or obtain more information, contact the plan's General Contact.

Model General Notice of COBRA Continuation Coverage Rights
** Continuation Coverage Rights Under COBRA **

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under Federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [*choose and enter appropriate information:* must pay *or* aren't required to pay] for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);

- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.
COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other

group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information:

General Contact: Jennifer Harker
Phone: 309-852-5696
Email: jharker@hsced.org
Mailing Address: 1318 W 6th Street, Kewanee, IL 61443

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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 8-31-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Jennifer Harker.

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] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name: **Henry Stark County Special Education District**		4. Employer Identification Number (EIN) **36-3052325**
5. Employer address: **1318 W 6th Street**		6. Employer phone number: **309-852-5696**
7. City: **Kewanee**	8. State: **Illinois**	7. Zip Code: **61443**
10. Who can we contact about employee health coverage at this job? **Jennifer Harker**		
11. Phone number (if different from above) **309-852-5696**	12. Email address **jharker@hsced.org**	

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

- As your employer, we offer a health plan to:

  [X] Some employees. Eligible employees are:

  All eligible employees who work more than 30 hours a week.

- With respect to dependents:

  [X] We do offer coverage. Eligible dependents are:

  Spouses and children under the age of 26 years old.

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

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

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

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