NON-CERTIFIED EMPLOYEES

2022 Employee Benefits Summary

Carrollton CUSD #1

PLAN YEAR | **9.1.2022 – 8.31.2023**

That's why at Carrollton we are committed to a comprehensive employee benefit program that helps our employees stay healthy, feel secure, and maintain a work/life balance.

Stay Healthy

- Medical Insurance
- Voluntary Dental Insurance
- Voluntary Vision Insurance

Feeling Secure

- Basic Life & AD&D Insurance
- Voluntary Term Life Insurance
- Employee Assistance Program (EAP)

Contact Information

Refer to this list when you need to contact one of your benefit vendors. For general information contact Becky Howard in the District Office. Additionally, please feel free to contact your dedicated Assured Partners Representatives –
Ashley Peterson @ 618.391.1046 or ashley.peterson@assuredpartners.com
Kari Unterbrink @ 618.391.1028 or kari.unterbrink@assuredpartners.com

MEDICAL:

United Healthcare
800.3570978
www.myuhc.com

DENTAL PLANS :

Guardian
800-541-7846
www.guardiananytime.com

VISION PLANS:

Guardian
800-541-7846
www.guardiananytime.com

BASIC LIFE /VOLUNTARY TERM LIFE INSURANCE:

Guardian
800-541-7846
www.guardiananytime.com

ENROLLMENT INFORMATION:

*****Medical Plans, Vision, Dental and Life Coverage benefits can be found on the following page and are brief summaries only. This information and all subsequent summaries are presented for illustrative purposes and are based on information provided by the employer. The text contained in this summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the benefits summary and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996.***

Medical Insurance

All full time eligible employees are offered the opportunity to enroll in the Carrollton School's health insurance plans administered by United Healthcare (UHC). Three plans are offered from which you may choose. The plans utilize the excellent local and national UHC networks, to provide you regional and nationwide physician access.

Who is Eligible and When:

- **All full time eligible employees**
  - Coverage begins 1st of the Month following date of hire
  - Coverage terms End of the Month

MEDICAL – OPTION 1	***Monthly Rates***
Employee Only	$56.66
Employee & Spouse	$804.60
Employee & Child(ren)	$658.38
Family	$1,406.32
MEDICAL – OPTION 2	***Monthly Rates***
Employee Only	$87.13
Employee & Spouse	$876.47
Employee & Child(ren)	$722.15
Family	$1,511.49
MEDICAL – OPTION 3	***Monthly Rates***
Employee Only	*$120.12*
Employee & Spouse	*$954.29*
Employee & Child(ren)	*$791.21*
Family	*$1,625.38*

Choice Plus plan details, all in one place.

Use this benefit summary to learn more about this plan's benefits, ways you can get help managing costs and how you may get more out of this health plan.

Check out what's included in the plan	Choice Plus
Network coverage only You can usually save money when you receive care for covered health care services from network providers.	☐
Network and out-of-network benefits You may receive care and services from network and out-of-network providers and facilities — but staying in the network can help lower your costs.	☑
Primary care physician (PCP) required With this plan, you need to select a PCP — the doctor who plays a key role in helping manage your care. Each enrolled person on your plan will need to choose a PCP.	☐
Referrals required You'll need referrals from your PCP before seeing a specialist or getting certain health care services.	☐
Preventive care covered at 100% There is no additional cost to you for seeing a network provider for preventive care.	☑
Pharmacy benefits With this plan, you have coverage that helps pay for prescription drugs and medications.	☑
Tier 1 providers Using Tier 1 providers may bring you the greatest value from your health care benefits. These PCPs and medical specialists meet national standard benchmarks for quality care and cost savings.	☐
Freestanding centers You may pay less when you use certain freestanding centers — health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers.	☐
Health savings account (HSA) With an HSA, you've got a personal bank account that lets you put money aside, tax-free. Use it to save and pay for qualified medical expenses.	☑

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Schedule of Benefits, Riders, and/or Amendments, those documents govern. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

Here's a more in-depth look at how Choice Plus works.

Medical Benefits

	In Network	Out-of-Network
Annual Medical Deductible		
Single Coverage	$1,500	$4,500
Family Coverage	$4,500	$9,000

No one in the family is eligible for benefits until the family coverage deductible is met.

**After the Annual Medical Deductible has been met.*

You're responsible for paying 100% of your medical expenses until you reach your deductible. For certain covered services, you may be required to pay a fixed dollar amount - your copay.

	In Network	Out-of-Network
Annual Out-of-Pocket Limit		
Single Coverage	$5,000	$10,000
Family Coverage	$6,850	$20,000

If more than one person in a family is covered under the Policy, the single coverage out-of-pocket limit does not apply.

Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network	Out-of-Network
Preventive Care Services		
Preventive Care Services *Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a copay, co-insurance or deductible.* *Includes services such as Routine Wellness Checkups, Immunizations, and Lab and X-ray services for Mammogram, Pap Smear, Prostate and Colorectal Cancer screenings.*	No copay	50%*
Office Services - Sickness & Injury		
Primary Care Physician *Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.* *Telehealth is covered at the same cost share as in the office.*	20%*	50%*
Specialist *Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.* *Telehealth is covered at the same cost share as in the office.*	20%*	50%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network	Out-of-Network
Urgent Care Center Services *Additional copays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.*	20%*	50%*
Virtual Care Services *Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.*	20%*	50%*
Emergency Care		
Ambulance Services - Emergency Ambulance		
Air Ambulance	20%*	20%*
Ground Ambulance	20%*	20%*
Ambulance Services - Non-Emergency Ambulance[1]		
Air Ambulance	20%*	20%*
Ground Ambulance	20%*	50%*
Dental Services - Accident Only	20%*	20%*
Emergency Health Care Services - Outpatient[1]	20%*	20%*
Inpatient Care		
Congenital Heart Disease (CHD) Surgeries[1]	20%*	50%*
Habilitative Services - Inpatient[1] *Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services for adults 19 years of age and older. For Dependents under 19 years of age, no limits apply.*	The amount you pay is based on where the covered health care service is provided.	
Hospital - Inpatient Stay[1]	20%*	50%*
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services[1] *Limited to 60 days per year.*	20%*	50%*
Outpatient Care		
Habilitative Services - Outpatient *Limits will be the same as, and combined with those stated under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment for adults 19 years of age and older. For Dependents under 19 years of age, no limits apply.* *Visit limits for Treatment for Autism Spectrum Disorders for Enrolled Dependents under 21 years of age do not apply.*	20%*	50%*

* After the Annual Medical Deductible has been met.

[1] Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network	Out-of-Network
Home Health Care[1] *Limited to 60 visits per year.* *One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.*	20%*	50%*
Lab, X-Ray and Diagnostic - Outpatient - Lab Testing[1]	20%*	50%*
Lab, X-Ray and Diagnostic - Outpatient - X-Ray and other Diagnostic Testing[1]	20%*	50%*
Major Diagnostic and Imaging - Outpatient[1] *You may have to pay an extra copay, deductible or coinsurance for physician fees or pharmaceutical products.*	20%*	50%*
Physician Fees for Surgical and Medical Services	20%*	50%*
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment *Limited to 20 visits of cognitive rehabilitation therapy per year.* *Limited to 20 visits of manipulative treatments per year.* *Limited to 20 visits of occupational therapy per year.* *Limited to 20 visits of physical therapy per year.* *Limited to 20 visits of pulmonary rehabilitation therapy per year.* *Limited to 20 visits of speech therapy per year.* *Limited to 30 visits of post-cochlear implant aural therapy per year.* *Limited to 36 visits of cardiac rehabilitation therapy per year.* *Limited to 60 visits of physical therapy for multiple sclerosis per year.* *Note: The first three network visits for any combination of physical therapy and Manipulative Treatment for new low back pain are not subject to any copay, co-insurance or deductible and subject to the annual visit limits.*	20%*	50%*
Scopic Procedures - Outpatient Diagnostic and Therapeutic *Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.*	20%*	50%*
Surgery - Outpatient[1]	20%*	50%*
Therapeutic Treatments - Outpatient[1] *Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.*	20%*	50%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services: Network	What You Pay for Services: Out-of-Network
Supplies and Services		
Diabetes Self-Management Items[1]	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies or in the Prescription Drug Benefits Section.	
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care[1]	The amount you pay is based on where the covered health care service is provided.	
Durable Medical Equipment (DME), Orthotics and Supplies[1] *Limited to a single purchase of a type of DME every 3 years.* *Repair and/or replacement of DME would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums.*	20%*	50%*
Enteral Nutrition	20%*	50%*
Hearing Aids *Limited to one hearing instrument per impaired ear every 24 months. Benefits include repairs and/or replacement of a hearing instrument when Medically Necessary.*	20%*	50%*
Ostomy Supplies *Limited to $2,500 per year.*	20%*	50%*
Pharmaceutical Products - Outpatient *This includes medications given at a doctor's office, or in a covered person's home.*	20%*	50%*
Prosthetic Devices[1]	20%*	50%*
Urinary Catheters	20%*	50%*
Pregnancy		
Pregnancy - Maternity Services[1]	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	
Mental Health Care & Substance Related and Addictive Disorder Services		
Inpatient[1]	20%*	50%*
Outpatient[1]	20%*	50%*
Partial Hospitalization[1]	20%*	50%*
Other Services		
Cellular and Gene Therapy[1] *For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.*	The amount you pay is based on where the covered health care service is provided.	
Clinical Trials[1]	The amount you pay is based on where the covered health care service is provided.	
Dental Services – Anesthesia and Facility	The amount you pay is based on where the covered health care service is provided.	

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Network	Out-of-Network
Examination and Treatment for Sexual Assault	No copay	No copay
Fertility Preservation for Iatrogenic Infertility[1]	20%*	50%*
Gender Dysphoria[1]	The amount you pay is based on where the covered health care service is provided or in the Prescription Drug Benefits Section.	
Hospice Care[1]	20%*	50%*
Human Breast Milk	20%*	50%*
Infertility Services[1] *Benefits for Assisted Reproductive Technology (ART) are limited to four oocyte retrievals per plan year; however, if a retrieval is followed by a live birth, two additional oocyte retrievals will be covered. Following the final oocyte retrieval, Benefits will be provided for one subsequent procedure to transfer the oocytes or sperm to the Covered Person.*	20%*	50%*
Port Wine Stain[1]	The amount you pay is based on where the covered health care service is provided.	
Preimplantation Genetic Testing (PGT) and Related Services[1] *Limited to $20,000 per Covered Person per lifetime.* *Limited to $5,000 for Prescription Drug Products for Infertility per Covered Person.* *This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This limit includes Benefits for ovarian stimulation medications provided under Outpatient Prescription Drugs.*	20%*	50%*
Reconstructive Procedures[1]	The amount you pay is based on where the covered health care service is provided.	
Telehealth Services	The amount you pay is based on where the covered health care service is provided.	
Temporomandibular Joint (TMJ) and Craniomandibular Disorder (CMD) Services[1]	The amount you pay is based on where the covered health care service is provided.	
Transplantation Services[1] *Network Benefits must be received from a Designated Provider.*	The amount you pay is based on where the covered health care service is provided.	

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Pharmacy Benefits

Pharmacy Plan Details	
Pharmacy Network	National
Prescription Drug List	Advantage
	In Network
Annual Pharmacy Deductible	
Individual	See the Annual Medical Deductible section
Family	See the Annual Medical Deductible section
Annual Deductible - Network and Out-of-Network *The Pharmacy Deductible is the amount you pay for pharmacy expenses per year before you begin to receive Pharmacy Benefits.*	

Prescription Drug Product Tier Level	Up to a 31-day supply		Up to a 90-day supply
	Retail Network	**Out-of-Network Pharmacy**	**Mail Order Network Pharmacy****
Tier 1 **$**	$10*	$10*	$25*
Tier 2 **$$**	$35*	$35*	$87.50*
Tier 3 **$$$**	$60*	$60*	$150*

* After the Annual Medical Deductible has been met.

** Only certain Prescription Drug Products are available through mail order; please visit myuhc.com® or call Customer Care at the telephone number on the back of your ID card for more information. You will be charged a retail Copayment and/or Coinsurance for 31 days or 2 times for 60 days based on the number of days supply dispensed for any Prescription Order or Refills sent to the mail order pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, rather than a 30-day supply with three refills.

Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3.

If you are a member, you can find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on myuhc.com® or calling the Customer Care number on your ID card. If you are not a member, you can view prescription information at welcometouhc.com > Benefits > Pharmacy Benefits.

For an out-of-network Pharmacy, you may have to pay the difference between the out-of-network reimbursement rate and the pharmacy's usual and customary charge.

Here's an example of how the plan's costs come into play.

At the start of your plan year...

You're responsible for paying 100% of your covered health services until you reach your **deductible**, which is the amount you pay before your health plan pays a portion.

YOU PAY 100%

Once you reach your deductible...

Your health plan starts to share a percentage of costs (the allowed amounts, excluding copays) for covered health care services with you—this is your **coinsurance**.*

YOU PAY 20%*

YOUR PLAN PAYS 80%

When you reach your out-of-pocket limit...

Your plan covers your costs (the allowed amount) at 100%. Your **out-of-pocket limit** is the most you'll pay for covered health services in a plan year—copays and coinsurance count toward this.

YOUR PLAN PAYS 100%

Along the way, you may also be required to pay a fixed amount (for example, $15)—or **copay**—for covered health care services, such as seeing a provider or purchasing a prescription. You pay 100% of the copay, usually when you receive the service.

* Your coinsurance may vary by service. This example is for illustrative purposes only.

More ways to help manage your health plan and stay in the loop.

Search the network to find doctors.

You can go to providers in and out of our network — but when you stay in network, you'll likely pay less for care. To get started:

- Go to welcometouhc.com **> Benefits > Find a Doctor or Facility.**
- Choose **Search for a health plan.**
- Choose **Choice Plus** to view providers in the health plan's network.

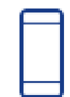
Manage your meds.

Look up your prescriptions using the Prescription Drug List (PDL). It places medications in tiers that represent what you'll pay, which may make it easier for you and your doctor to find options to help you save money.

- Go to welcometouhc.com **> Benefits > Pharmacy Benefits.**
- Select **Advantage** to view the medications that are covered under your plan.

Access your plan online.

With myuhc.com®, you've got a personalized health hub to help you find a doctor, manage your claims, estimate costs and more.



Get on-the-go access.

When you're out and about, the UnitedHealthcare® app puts your health plan at your fingertips. Download to find nearby care, video chat with a doctor 24/7, access your health plan ID card and more.

Other important information about your benefits.

Medical Exclusions

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult/Child)
- Glasses
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing
- Routine Eye Care (Adult/Child)
- Routine Foot Care
- Weight Loss Programs

Outpatient Prescription Drug Benefits

For Prescription Drug Products dispensed at a retail Network Pharmacy, you are responsible for paying the lowest of the following: 1) The applicable Copayment and/or Coinsurance; 2) The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product; and 3) The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: 1) The applicable Copayment and/or Coinsurance; and 2) The Prescription Drug Charge for that Prescription Drug Product.

See the Copayment and/or Coinsurance stated in the Benefit Information table for amounts. We will not reimburse you for any non-covered drug product.

For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, a Non-Preferred Specialty Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.

Certain Prescription Drug Products for which Benefits are described under the Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first. You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at myuhc.com or the telephone number on your ID card.

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee to determine whether the Prescription Drug Product is in accordance with our approved guidelines and it meets the definition of a Covered Health Care Service and is not an Experimental or Investigational or Unproven Service. We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

Certain Preventative Care Medications may be covered at zero cost share. You can get more information by contacting us at myuhc.com or the telephone number on your ID card.

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy. The Outpatient Prescription Drug Schedule of Benefits will tell you how mail order Network Pharmacy and Preferred 90 Day Retail Network Pharmacy supply limits apply. Please contact us at myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

Other important information about your benefits.

Pharmacy Exclusions

The following exclusions apply. In addition see your Pharmacy Rider and SBN for additional exclusions and limitations that may apply.

- A Pharmaceutical Product for which Benefits are provided in your Certificate.
- A Prescription Drug Product with either: an approved biosimilar, a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.
- Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare).
- Any product dispensed for the purpose of appetite suppression or weight loss.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury. This exclusion does not apply to amino acid-based elemental formulas, as described in Section 1 of the COC, for the treatment of Eosinophilic Disorders and short bowel syndrome as prescribed by a Physician.
- Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our PDL Management Committee.
- Certain Prescription Drug Products for tobacco cessation.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available.
- Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors.
- Certain compounded drugs.
- Diagnostic kits and products, including associated services.
- Drugs available over-the-counter. This exclusion does not apply to over-the-counter FDA-approved contraceptive drugs, devices, and products, excluding male condoms, as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration and as required by Illinois law when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under Preventive Care Services in Section 1 of the COC.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Certificate. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
- Experimental or Investigational or Unproven Services and medications. This exclusion does not include a Prescription Drug Product that has been prescribed for the treatment of a type of cancer for which the Prescription Drug Product has not yet been approved by the (FDA), if the Prescription Drug Product is recognized for the specific treatment for which it was prescribed.
- General vitamins, except Prenatal vitamins, vitamins with fluoride, and single entity vitamins when accompanied by a Prescription Order or Refill.
- Growth hormone therapy, except when determined necessary by your Physician.
- Medications used for cosmetic purposes.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that do not meet the definition of a Covered Health Care Service.
- Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

Choice Plus plan details, all in one place.

Use this benefit summary to learn more about this plan's benefits, ways you can get help managing costs and how you may get more out of this health plan.

Check out what's included in the plan	Choice Plus
Network coverage only You can usually save money when you receive care for covered health care services from network providers.	☐
Network and out-of-network benefits You may receive care and services from network and out-of-network providers and facilities — but staying in the network can help lower your costs.	☑
Primary care physician (PCP) required With this plan, you need to select a PCP — the doctor who plays a key role in helping manage your care. Each enrolled person on your plan will need to choose a PCP.	☐
Referrals required You'll need referrals from your PCP before seeing a specialist or getting certain health care services.	☐
Preventive care covered at 100% There is no additional cost to you for seeing a network provider for preventive care.	☑
Pharmacy benefits With this plan, you have coverage that helps pay for prescription drugs and medications.	☑
Tier 1 providers Using Tier 1 providers may bring you the greatest value from your health care benefits. These PCPs and medical specialists meet national standard benchmarks for quality care and cost savings.	☑
Freestanding centers You may pay less when you use certain freestanding centers — health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers.	☐
Health savings account (HSA) With an HSA, you've got a personal bank account that lets you put money aside, tax-free. Use it to save and pay for qualified medical expenses.	☐

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Schedule of Benefits, Riders, and/or Amendments, those documents govern. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

Here's a more in-depth look at how Choice Plus works.

Medical Benefits

	In Network	Out-of-Network
Annual Medical Deductible		
Individual	$3,000	$9,000
Family	$6,000	$18,000

All individual deductible amounts will count toward the family deductible, but an individual will not have to pay more than the individual deductible amount.

**After the Annual Medical Deductible has been met.*

You're responsible for paying 100% of your medical expenses until you reach your deductible. For certain covered services, you may be required to pay a fixed dollar amount - your copay.

	In Network	Out-of-Network
Annual Out-of-Pocket Limit		
Individual	$6,250	$12,500
Family	$12,500	$25,000

All individual out-of-pocket maximum amounts will count toward the family out-of-pocket maximum, but an individual will not have to pay more than the individual out-of-pocket maximum amount.

Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Preventive Care Services			
Preventive Care Services		No copay	50%*
Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a copay, co-insurance or deductible.			
Includes services such as Routine Wellness Checkups, Immunizations, and Lab and X-ray services for Mammogram, Pap Smear, Prostate and Colorectal Cancer screenings.			
Office Services - Sickness & Injury			
Primary Care Physician			
All other covered persons		$35 copay	50%*
Covered persons less than age 19		No copay	50%*
Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.			
Telehealth is covered at the same cost share as in the office.			

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Specialist *Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.* *Telehealth is covered at the same cost share as in the office.*		$70 copay	50%*
Urgent Care Center Services *Additional copays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.*		$50 copay	50%*
Virtual Care Services *Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.*		No copay	50%*
Emergency Care			
Ambulance Services - Emergency Ambulance			
Air Ambulance		20%*	20%*
Ground Ambulance		20%*	20%*
Ambulance Services - Non-Emergency Ambulance[1]			
Air Ambulance		20%*	20%*
Ground Ambulance		20%*	50%*
Dental Services - Accident Only		20%*	20%*
Emergency Health Care Services - Outpatient[1]		20%*	20%*
Inpatient Care			
Congenital Heart Disease (CHD) Surgeries[1]		20%*	50%*
Habilitative Services - Inpatient[1] *Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services for adults 19 years of age and older. For Dependents under 19 years of age, no limits apply.*	The amount you pay is based on where the covered health care service is provided.		
Hospital - Inpatient Stay[1]		20%*	50%*
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services[1] *Limited to 60 days per year.*		20%*	50%*

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Outpatient Care			
Habilitative Services - Outpatient *Limits will be the same as, and combined with those stated under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment for adults 19 years of age and older. For Dependents under 19 years of age, no limits apply.* *Visit limits for Treatment for Autism Spectrum Disorders for Enrolled Dependents under 21 years of age do not apply.*		$35 copay	50%*
Home Health Care[1] *Limited to 60 visits per year.* *One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.*		20%*	50%*
Lab, X-Ray and Diagnostic - Outpatient - Lab Testing[1]	No copay	20%*	50%*
Lab, X-Ray and Diagnostic - Outpatient - X-Ray and other Diagnostic Testing[1]		20%*	50%*
Major Diagnostic and Imaging - Outpatient[1] *You may have to pay an extra copay, deductible or coinsurance for physician fees or pharmaceutical products.*		$400 copay	50%*
Physician Fees for Surgical and Medical Services		20%*	50%*
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment *Limited to 20 visits of cognitive rehabilitation therapy per year.* *Limited to 20 visits of manipulative treatments per year.* *Limited to 20 visits of occupational therapy per year.* *Limited to 20 visits of physical therapy per year.* *Limited to 20 visits of pulmonary rehabilitation therapy per year.* *Limited to 20 visits of speech therapy per year.* *Limited to 30 visits of post-cochlear implant aural therapy per year.* *Limited to 36 visits of cardiac rehabilitation therapy per year.* *Limited to 60 visits of physical therapy for multiple sclerosis per year.* *Note: The first three network visits for any combination of physical therapy and Manipulative Treatment for new low back pain are not subject to any copay, co-insurance or deductible and subject to the annual visit limits.*		$35 copay	50%*
Scopic Procedures - Outpatient Diagnostic and Therapeutic *Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.*		20%*	50%*
Surgery - Outpatient[1]		20%*	50%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services: Designated Network	Network	Out-of-Network
Therapeutic Treatments - Outpatient[1] *Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.*		20%*	50%*
Supplies and Services			
Diabetes Self-Management Items[1]	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies or in the Prescription Drug Benefits Section.		
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care[1]	The amount you pay is based on where the covered health care service is provided.		
Durable Medical Equipment (DME), Orthotics and Supplies[1] *Limited to a single purchase of a type of DME every 3 years.* *Repair and/or replacement of DME would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums.*		20%*	50%*
Enteral Nutrition		20%*	50%*
Hearing Aids *Limited to one hearing instrument per impaired ear every 24 months. Benefits include repairs and/or replacement of a hearing instrument when Medically Necessary.*		20%*	50%*
Ostomy Supplies *Limited to $2,500 per year.*		20%*	50%*
Pharmaceutical Products - Outpatient *This includes medications given at a doctor's office, or in a covered person's home.*		20%*	50%*
Prosthetic Devices[1]		20%*	50%*
Urinary Catheters		20%*	50%*
Pregnancy			
Pregnancy - Maternity Services[1]	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
Mental Health Care & Substance Related and Addictive Disorder Services			
Inpatient[1]		20%*	50%*
Outpatient[1]		$35 copay	50%*
Partial Hospitalization[1]		20%*	50%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Other Services			
Cellular and Gene Therapy[1] *For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.*	The amount you pay is based on where the covered health care service is provided.		
Clinical Trials[1]	The amount you pay is based on where the covered health care service is provided.		
Dental Services – Anesthesia and Facility	The amount you pay is based on where the covered health care service is provided.		
Examination and Treatment for Sexual Assault		No copay	No copay
Fertility Preservation for Iatrogenic Infertility[1]		20%*	50%*
Gender Dysphoria[1]	The amount you pay is based on where the covered health care service is provided or in the Prescription Drug Benefits Section.		
Hospice Care[1]		20%*	50%*
Human Breast Milk		20%*	50%*
Infertility Services[1] *Benefits for Assisted Reproductive Technology (ART) are limited to four oocyte retrievals per plan year; however, if a retrieval is followed by a live birth, two additional oocyte retrievals will be covered. Following the final oocyte retrieval, Benefits will be provided for one subsequent procedure to transfer the oocytes or sperm to the Covered Person.*		20%*	50%*
Port Wine Stain[1]	The amount you pay is based on where the covered health care service is provided.		
Preimplantation Genetic Testing (PGT) and Related Services[1] *Limited to $20,000 per Covered Person per lifetime.* *Limited to $5,000 for Prescription Drug Products for Infertility per Covered Person.* *This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This limit includes Benefits for ovarian stimulation medications provided under Outpatient Prescription Drugs.*		20%*	50%*
Reconstructive Procedures[1]	The amount you pay is based on where the covered health care service is provided.		
Telehealth Services	The amount you pay is based on where the covered health care service is provided.		
Temporomandibular Joint (TMJ) and Craniomandibular Disorder (CMD) Services[1]	The amount you pay is based on where the covered health care service is provided.		
Transplantation Services[1] *Network Benefits must be received from a Designated Provider.*	The amount you pay is based on where the covered health care service is provided.		

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Pharmacy Benefits

Pharmacy Plan Details	
Pharmacy Network	National
Prescription Drug List	Advantage

	In Network
Annual Pharmacy Deductible	
Individual	You do not have to pay a pharmacy deductible
Family	You do not have to pay a pharmacy deductible

	Up to a 31-day supply		Up to a 90-day supply
Prescription Drug Product Tier Level	**Retail Network**	**Out-of-Network Pharmacy**	**Mail Order Network Pharmacy****
Tier 1 **$**	$10	$10	$25
Tier 2 **$$**	$35	$35	$87.50
Tier 3 **$$$**	$60	$60	$150

* After the Annual Medical Deductible has been met.

** Only certain Prescription Drug Products are available through mail order; please visit myuhc.com® or call Customer Care at the telephone number on the back of your ID card for more information. You will be charged a retail Copayment and/or Coinsurance for 31 days or 2 times for 60 days based on the number of days supply dispensed for any Prescription Order or Refills sent to the mail order pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, rather than a 30-day supply with three refills.

Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3.

If you are a member, you can find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on myuhc.com® or calling the Customer Care number on your ID card. If you are not a member, you can view prescription information at welcometouhc.com > Benefits > Pharmacy Benefits.

For an out-of-network Pharmacy, you may have to pay the difference between the out-of-network reimbursement rate and the pharmacy's usual and customary charge.

Here’s an example of how the plan’s costs come into play.

At the start of your plan year...

You’re responsible for paying 100% of your covered health services until you reach your **deductible**, which is the amount you pay before your health plan pays a portion.

YOU PAY 100%

Once you reach your deductible...

Your health plan starts to share a percentage of costs (the allowed amounts, excluding copays) for covered health care services with you—this is your **coinsurance**.*

YOU PAY 20%*

YOUR PLAN PAYS 80%

When you reach your out-of-pocket limit...

Your plan covers your costs (the allowed amount) at 100%. Your **out-of-pocket limit** is the most you’ll pay for covered health services in a plan year—copays and coinsurance count toward this.

YOUR PLAN PAYS 100%

Along the way, you may also be required to pay a fixed amount (for example, $15)—or **copay**—for covered health care services, such as seeing a provider or purchasing a prescription. You pay 100% of the copay, usually when you receive the service.

* Your coinsurance may vary by service. This example is for illustrative purposes only.

More ways to help manage your health plan and stay in the loop.

Search the network to find doctors.

You can go to providers in and out of our network — but when you stay in network, you’ll likely pay less for care. To get started:

- Go to welcometouhc.com **> Benefits > Find a Doctor or Facility.**
- Choose **Search for a health plan.**
- Choose **Choice Plus** to view providers in the health plan’s network.

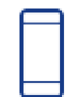
Manage your meds.

Look up your prescriptions using the Prescription Drug List (PDL). It places medications in tiers that represent what you’ll pay, which may make it easier for you and your doctor to find options to help you save money.

- Go to welcometouhc.com **> Benefits > Pharmacy Benefits.**
- Select **Advantage** to view the medications that are covered under your plan.

Access your plan online.

With myuhc.com®, you’ve got a personalized health hub to help you find a doctor, manage your claims, estimate costs and more.



Get on-the-go access.

When you’re out and about, the UnitedHealthcare® app puts your health plan at your fingertips. Download to find nearby care, video chat with a doctor 24/7, access your health plan ID card and more.

Other important information about your benefits.

Medical Exclusions

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult/Child)
- Glasses
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing
- Routine Eye Care (Adult/Child)
- Routine Foot Care
- Weight Loss Programs

Outpatient Prescription Drug Benefits

For Prescription Drug Products dispensed at a retail Network Pharmacy, you are responsible for paying the lowest of the following: 1) The applicable Copayment and/or Coinsurance; 2) The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product; and 3) The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: 1) The applicable Copayment and/or Coinsurance; and 2) The Prescription Drug Charge for that Prescription Drug Product.

See the Copayment and/or Coinsurance stated in the Benefit Information table for amounts. We will not reimburse you for any non-covered drug product.

For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, a Non-Preferred Specialty Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.

Certain Prescription Drug Products for which Benefits are described under the Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first. You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at myuhc.com or the telephone number on your ID card.

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee to determine whether the Prescription Drug Product is in accordance with our approved guidelines and it meets the definition of a Covered Health Care Service and is not an Experimental or Investigational or Unproven Service. We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

Certain Preventative Care Medications may be covered at zero cost share. You can get more information by contacting us at myuhc.com or the telephone number on your ID card.

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy. The Outpatient Prescription Drug Schedule of Benefits will tell you how mail order Network Pharmacy and Preferred 90 Day Retail Network Pharmacy supply limits apply. Please contact us at myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

Other important information about your benefits.

Pharmacy Exclusions

The following exclusions apply. In addition see your Pharmacy Rider and SBN for additional exclusions and limitations that may apply.

- A Pharmaceutical Product for which Benefits are provided in your Certificate.
- A Prescription Drug Product with either: an approved biosimilar, a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.
- Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare).
- Any product dispensed for the purpose of appetite suppression or weight loss.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury. This exclusion does not apply to amino acid-based elemental formulas, as described in Section 1 of the COC, for the treatment of Eosinophilic Disorders and short bowel syndrome as prescribed by a Physician.
- Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our PDL Management Committee.
- Certain Prescription Drug Products for tobacco cessation.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available.
- Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors.
- Certain compounded drugs.
- Diagnostic kits and products, including associated services.
- Drugs available over-the-counter. This exclusion does not apply to over-the-counter FDA-approved contraceptive drugs, devices, and products, excluding male condoms, as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration and as required by Illinois law when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under Preventive Care Services in Section 1 of the COC.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Certificate. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
- Experimental or Investigational or Unproven Services and medications. This exclusion does not include a Prescription Drug Product that has been prescribed for the treatment of a type of cancer for which the Prescription Drug Product has not yet been approved by the (FDA), if the Prescription Drug Product is recognized for the specific treatment for which it was prescribed.
- General vitamins, except Prenatal vitamins, vitamins with fluoride, and single entity vitamins when accompanied by a Prescription Order or Refill.
- Growth hormone therapy, except when determined necessary by your Physician.
- Medications used for cosmetic purposes.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that do not meet the definition of a Covered Health Care Service.
- Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

Choice Plus plan details, all in one place.

Use this benefit summary to learn more about this plan's benefits, ways you can get help managing costs and how you may get more out of this health plan.

Check out what's included in the plan	Choice Plus
Network coverage only You can usually save money when you receive care for covered health care services from network providers.	☐
Network and out-of-network benefits You may receive care and services from network and out-of-network providers and facilities — but staying in the network can help lower your costs.	☑
Primary care physician (PCP) required With this plan, you need to select a PCP — the doctor who plays a key role in helping manage your care. Each enrolled person on your plan will need to choose a PCP.	☐
Referrals required You'll need referrals from your PCP before seeing a specialist or getting certain health care services.	☐
Preventive care covered at 100% There is no additional cost to you for seeing a network provider for preventive care.	☑
Pharmacy benefits With this plan, you have coverage that helps pay for prescription drugs and medications.	☑
Tier 1 providers Using Tier 1 providers may bring you the greatest value from your health care benefits. These PCPs and medical specialists meet national standard benchmarks for quality care and cost savings.	☑
Freestanding centers You may pay less when you use certain freestanding centers — health care facilities that do not bill for services as part of a hospital, such as MRI or surgery centers.	☐
Health savings account (HSA) With an HSA, you've got a personal bank account that lets you put money aside, tax-free. Use it to save and pay for qualified medical expenses.	☐

This Benefit Summary is to highlight your Benefits. Don't use this document to understand your exact coverage. If this Benefit Summary conflicts with the Certificate of Coverage (COC), Schedule of Benefits, Riders, and/or Amendments, those documents govern. Review your COC for an exact description of the services and supplies that are and are not covered, those which are excluded or limited, and other terms and conditions of coverage.

Here's a more in-depth look at how Choice Plus works.

Medical Benefits

	In Network	Out-of-Network
Annual Medical Deductible		
Individual	$1,500	$4,500
Family	$3,000	$9,000

All individual deductible amounts will count toward the family deductible, but an individual will not have to pay more than the individual deductible amount.

**After the Annual Medical Deductible has been met.*

You're responsible for paying 100% of your medical expenses until you reach your deductible. For certain covered services, you may be required to pay a fixed dollar amount - your copay.

Annual Out-of-Pocket Limit		
Individual	$6,250	$12,500
Family	$12,500	$25,000

All individual out-of-pocket maximum amounts will count toward the family out-of-pocket maximum, but an individual will not have to pay more than the individual out-of-pocket maximum amount.

Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Preventive Care Services			
Preventive Care Services		No copay	50%*
Certain preventive care services are provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services are based on your age, gender and other health factors. UnitedHealthcare also covers other routine services that may require a copay, co-insurance or deductible.			
Includes services such as Routine Wellness Checkups, Immunizations, and Lab and X-ray services for Mammogram, Pap Smear, Prostate and Colorectal Cancer screenings.			
Office Services - Sickness & Injury			
Primary Care Physician			
All other covered persons		$35 copay	50%*
Covered persons less than age 19		No copay	50%*
Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.			
Telehealth is covered at the same cost share as in the office.			

*After the Annual Medical Deductible has been met.

¹Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Specialist *Additional copays, deductible, or co-insurance may apply when you receive other services at your physician's office. For example, surgery and lab work.* *Telehealth is covered at the same cost share as in the office.*		$70 copay	50%*
Urgent Care Center Services *Additional copays, deductible, or co-insurance may apply when you receive other services at the urgent care facility. For example, surgery and lab work.*		$50 copay	50%*
Virtual Care Services *Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Visit Network Provider by contacting us at myuhc.com® or the telephone number on your ID card. Access to Virtual Visits and prescription services may not be available in all states or for all groups.*		No copay	50%*
Emergency Care			
Ambulance Services - Emergency Ambulance			
Air Ambulance		20%*	20%*
Ground Ambulance		20%*	20%*
Ambulance Services - Non-Emergency Ambulance[1]			
Air Ambulance		20%*	20%*
Ground Ambulance		20%*	50%*
Dental Services - Accident Only		20%*	20%*
Emergency Health Care Services - Outpatient[1]		20%*	20%*
Inpatient Care			
Congenital Heart Disease (CHD) Surgeries[1]		20%*	50%*
Habilitative Services - Inpatient[1] *Limit will be the same as, and combined with, those stated under Skilled Nursing Facility/Inpatient Rehabilitation Services for adults 19 years of age and older. For Dependents under 19 years of age, no limits apply.*	The amount you pay is based on where the covered health care service is provided.		
Hospital - Inpatient Stay[1]		20%*	50%*
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services[1] *Limited to 60 days per year.*		20%*	50%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Copays ($) and Coinsurance (%) for Covered Health Care Services	What You Pay for Services Designated Network	Network	Out-of-Network
Outpatient Care			
Habilitative Services - Outpatient *Limits will be the same as, and combined with those stated under Rehabilitation Services - Outpatient Therapy and Manipulative Treatment for adults 19 years of age and older. For Dependents under 19 years of age, no limits apply.* *Visit limits for Treatment for Autism Spectrum Disorders for Enrolled Dependents under 21 years of age do not apply.*		$35 copay	50%*
Home Health Care[1] *Limited to 60 visits per year.* *One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.*		20%*	50%*
Lab, X-Ray and Diagnostic - Outpatient - Lab Testing[1]	No copay	20%*	50%*
Lab, X-Ray and Diagnostic - Outpatient - X-Ray and other Diagnostic Testing[1]		20%*	50%*
Major Diagnostic and Imaging - Outpatient[1] *You may have to pay an extra copay, deductible or coinsurance for physician fees or pharmaceutical products.*		$400 copay	50%*
Physician Fees for Surgical and Medical Services		20%*	50%*
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment *Limited to 20 visits of cognitive rehabilitation therapy per year.* *Limited to 20 visits of manipulative treatments per year.* *Limited to 20 visits of occupational therapy per year.* *Limited to 20 visits of physical therapy per year.* *Limited to 20 visits of pulmonary rehabilitation therapy per year.* *Limited to 20 visits of speech therapy per year.* *Limited to 30 visits of post-cochlear implant aural therapy per year.* *Limited to 36 visits of cardiac rehabilitation therapy per year.* *Limited to 60 visits of physical therapy for multiple sclerosis per year.* *Note: The first three network visits for any combination of physical therapy and Manipulative Treatment for new low back pain are not subject to any copay, co-insurance or deductible and subject to the annual visit limits.*		$35 copay	50%*
Scopic Procedures - Outpatient Diagnostic and Therapeutic *Diagnostic/therapeutic scopic procedures include, but are not limited to colonoscopy, sigmoidoscopy and endoscopy.*		20%*	50%*
Surgery - Outpatient[1]		20%*	50%*

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Therapeutic Treatments - Outpatient[1] *Therapeutic treatments include, but are not limited to dialysis, intravenous chemotherapy, intravenous infusion, medical education services and radiation oncology.*		20%*	50%*
Supplies and Services			
Diabetes Self-Management Items[1]	The amount you pay is based on where the covered health care service is provided under Durable Medical Equipment (DME), Orthotics and Supplies or in the Prescription Drug Benefits Section.		
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care[1]	The amount you pay is based on where the covered health care service is provided.		
Durable Medical Equipment (DME), Orthotics and Supplies[1] *Limited to a single purchase of a type of DME every 3 years.* *Repair and/or replacement of DME would apply to this limit in the same manner as a purchase. This limit does not apply to wound vacuums.*		20%*	50%*
Enteral Nutrition		20%*	50%*
Hearing Aids *Limited to one hearing instrument per impaired ear every 24 months. Benefits include repairs and/or replacement of a hearing instrument when Medically Necessary.*		20%*	50%*
Ostomy Supplies *Limited to $2,500 per year.*		20%*	50%*
Pharmaceutical Products - Outpatient *This includes medications given at a doctor's office, or in a covered person's home.*		20%*	50%*
Prosthetic Devices[1]		20%*	50%*
Urinary Catheters		20%*	50%*
Pregnancy			
Pregnancy - Maternity Services[1]	The amount you pay is based on where the covered health care service is provided except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
Mental Health Care & Substance Related and Addictive Disorder Services			
Inpatient[1]		20%*	50%*
Outpatient[1]		$35 copay	50%*
Partial Hospitalization[1]		20%*	50%*

*After the Annual Medical Deductible has been met.
[1]Prior Authorization Required. Refer to COC/SBN.

What You Pay for Services

Copays ($) and Coinsurance (%) for Covered Health Care Services	Designated Network	Network	Out-of-Network
Other Services			
Cellular and Gene Therapy[1] *For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.*	The amount you pay is based on where the covered health care service is provided.		
Clinical Trials[1]	The amount you pay is based on where the covered health care service is provided.		
Dental Services – Anesthesia and Facility	The amount you pay is based on where the covered health care service is provided.		
Examination and Treatment for Sexual Assault		No copay	No copay
Fertility Preservation for Iatrogenic Infertility[1]		20%*	50%*
Gender Dysphoria[1]	The amount you pay is based on where the covered health care service is provided or in the Prescription Drug Benefits Section.		
Hospice Care[1]		20%*	50%*
Human Breast Milk		20%*	50%*
Infertility Services[1] *Benefits for Assisted Reproductive Technology (ART) are limited to four oocyte retrievals per plan year; however, if a retrieval is followed by a live birth, two additional oocyte retrievals will be covered. Following the final oocyte retrieval, Benefits will be provided for one subsequent procedure to transfer the oocytes or sperm to the Covered Person.*		20%*	50%*
Port Wine Stain[1]	The amount you pay is based on where the covered health care service is provided.		
Preimplantation Genetic Testing (PGT) and Related Services[1] *Limited to $20,000 per Covered Person per lifetime.* *Limited to $5,000 for Prescription Drug Products for Infertility per Covered Person.* *This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder. This limit includes Benefits for ovarian stimulation medications provided under Outpatient Prescription Drugs.*		20%*	50%*
Reconstructive Procedures[1]	The amount you pay is based on where the covered health care service is provided.		
Telehealth Services	The amount you pay is based on where the covered health care service is provided.		
Temporomandibular Joint (TMJ) and Craniomandibular Disorder (CMD) Services[1]	The amount you pay is based on where the covered health care service is provided.		
Transplantation Services[1] *Network Benefits must be received from a Designated Provider.*	The amount you pay is based on where the covered health care service is provided.		

*After the Annual Medical Deductible has been met.

[1]Prior Authorization Required. Refer to COC/SBN.

Pharmacy Benefits

Pharmacy Plan Details	
Pharmacy Network	National
Prescription Drug List	Advantage

	In Network
Annual Pharmacy Deductible	
Individual	You do not have to pay a pharmacy deductible
Family	You do not have to pay a pharmacy deductible

	Up to a 31-day supply		Up to a 90-day supply
Prescription Drug Product Tier Level	**Retail Network**	**Out-of-Network Pharmacy**	**Mail Order Network Pharmacy****
Tier 1 **$**	$10	$10	$25
Tier 2 **$$**	$35	$35	$87.50
Tier 3 **$$$**	$60	$60	$150

* After the Annual Medical Deductible has been met.

** Only certain Prescription Drug Products are available through mail order; please visit myuhc.com® or call Customer Care at the telephone number on the back of your ID card for more information. You will be charged a retail Copayment and/or Coinsurance for 31 days or 2 times for 60 days based on the number of days supply dispensed for any Prescription Order or Refills sent to the mail order pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate, rather than a 30-day supply with three refills.

Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3.

If you are a member, you can find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging into your account on myuhc.com® or calling the Customer Care number on your ID card. If you are not a member, you can view prescription information at welcometouhc.com > Benefits > Pharmacy Benefits.

For an out-of-network Pharmacy, you may have to pay the difference between the out-of-network reimbursement rate and the pharmacy's usual and customary charge.

Here's an example of how the plan's costs come into play.

At the start of your plan year...

You're responsible for paying 100% of your covered health services until you reach your **deductible**, which is the amount you pay before your health plan pays a portion.

YOU PAY 100%

Your health plan starts to share a percentage of costs (the allowed amounts, excluding copays) for covered health care services with you—this is your **coinsurance**.*

YOU PAY 20%*

YOUR PLAN PAYS 80%

Your plan covers your costs (the allowed amount) at 100%. Your **out-of-pocket limit** is the most you'll pay for covered health services in a plan year—copays and coinsurance count toward this.

YOUR PLAN PAYS 100%

Along the way, you may also be required to pay a fixed amount (for example, $15)—or **copay**—for covered health care services, such as seeing a provider or purchasing a prescription. You pay 100% of the copay, usually when you receive the service.

* Your coinsurance may vary by service. This example is for illustrative purposes only.

More ways to help manage your health plan and stay in the loop.

Search the network to find doctors.

You can go to providers in and out of our network — but when you stay in network, you'll likely pay less for care. To get started:

- Go to welcometouhc.com **> Benefits > Find a Doctor or Facility.**
- Choose **Search for a health plan.**
- Choose **Choice Plus** to view providers in the health plan's network.

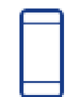
Manage your meds.

Look up your prescriptions using the Prescription Drug List (PDL). It places medications in tiers that represent what you'll pay, which may make it easier for you and your doctor to find options to help you save money.

- Go to welcometouhc.com **> Benefits > Pharmacy Benefits.**
- Select **Advantage** to view the medications that are covered under your plan.

Access your plan online.

With myuhc.com®, you've got a personalized health hub to help you find a doctor, manage your claims, estimate costs and more.



Get on-the-go access.

When you're out and about, the UnitedHealthcare® app puts your health plan at your fingertips. Download to find nearby care, video chat with a doctor 24/7, access your health plan ID card and more.

Other important information about your benefits.

Medical Exclusions

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult/Child)
- Glasses
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Private-Duty Nursing
- Routine Eye Care (Adult/Child)
- Routine Foot Care
- Weight Loss Programs

Outpatient Prescription Drug Benefits

For Prescription Drug Products dispensed at a retail Network Pharmacy, you are responsible for paying the lowest of the following: 1) The applicable Copayment and/or Coinsurance; 2) The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product; and 3) The Prescription Drug Charge for that Prescription Drug Product. For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following: 1) The applicable Copayment and/or Coinsurance; and 2) The Prescription Drug Charge for that Prescription Drug Product.

See the Copayment and/or Coinsurance stated in the Benefit Information table for amounts. We will not reimburse you for any non-covered drug product.

For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit. Some products are subject to additional supply limits based on criteria that we have developed. Supply limits are subject, from time to time, to our review and change.

Specialty Prescription Drug Products supply limits are as written by the provider, up to a consecutive 31-day supply of the Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits, or as allowed under the Smart Fill Program. Supply limits apply to Specialty Prescription Drug Products obtained at a Preferred Specialty Network Pharmacy, a Non-Preferred Specialty Network Pharmacy, an out-of-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.

Certain Prescription Drug Products for which Benefits are described under the Prescription Drug Rider are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) first. You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting us at myuhc.com or the telephone number on your ID card.

Before certain Prescription Drug Products are dispensed to you, your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee to determine whether the Prescription Drug Product is in accordance with our approved guidelines and it meets the definition of a Covered Health Care Service and is not an Experimental or Investigational or Unproven Service. We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist.

Certain Preventative Care Medications may be covered at zero cost share. You can get more information by contacting us at myuhc.com or the telephone number on your ID card.

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy. The Outpatient Prescription Drug Schedule of Benefits will tell you how mail order Network Pharmacy and Preferred 90 Day Retail Network Pharmacy supply limits apply. Please contact us at myuhc.com or the telephone number on your ID card to find out if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy.

Other important information about your benefits.

Pharmacy Exclusions

The following exclusions apply. In addition see your Pharmacy Rider and SBN for additional exclusions and limitations that may apply.

- A Pharmaceutical Product for which Benefits are provided in your Certificate.
- A Prescription Drug Product with either: an approved biosimilar, a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product.
- Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare).
- Any product dispensed for the purpose of appetite suppression or weight loss.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury. This exclusion does not apply to amino acid-based elemental formulas, as described in Section 1 of the COC, for the treatment of Eosinophilic Disorders and short bowel syndrome as prescribed by a Physician.
- Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by our PDL Management Committee.
- Certain Prescription Drug Products for tobacco cessation.
- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available.
- Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors.
- Certain compounded drugs.
- Diagnostic kits and products, including associated services.
- Drugs available over-the-counter. This exclusion does not apply to over-the-counter FDA-approved contraceptive drugs, devices, and products, excluding male condoms, as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration and as required by Illinois law when prescribed by a Network provider for which Benefits are available, without cost sharing, as described under Preventive Care Services in Section 1 of the COC.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
- Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Certificate. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.
- Experimental or Investigational or Unproven Services and medications. This exclusion does not include a Prescription Drug Product that has been prescribed for the treatment of a type of cancer for which the Prescription Drug Product has not yet been approved by the (FDA), if the Prescription Drug Product is recognized for the specific treatment for which it was prescribed.
- General vitamins, except Prenatal vitamins, vitamins with fluoride, and single entity vitamins when accompanied by a Prescription Order or Refill.
- Growth hormone therapy, except when determined necessary by your Physician.
- Medications used for cosmetic purposes.
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that do not meet the definition of a Covered Health Care Service.
- Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

Medical Insurance
Wellness Programs

The following pages are flyers on Wellness Programs offered through United Healthcare. These programs are only available if you are enrolled in Medical coverage.

- **Simply Engaged** – heath and wellness activities such as a *Fitness Reimbursement* Program, *Real Appeal* and *Quit for Life* (smoking cessation program)
- **Apple Fitness+** – 12 months of Apple Fitness+ added to our plan at no additional cost
- **Virtual Visits** – Access to non-emergent care online via computer/tablet/phone.
- EAP- Employee Assistance Program - free consueling sessions available 24/7

Who is Eligible and When:

- **All full time eligible employees**
  - Coverage begins 1st of the Month following date of hire
  - Coverage terms End of the Month

Earn up to $240* for completing health and wellness activities.

With SimplyEngaged, you can get rewarded for taking healthier actions.

Here's how SimplyEngaged works.

Through Rally®, you can access the SimplyEngaged® health and wellness activities available to you. For each Health Action you complete, you'll earn Rally Coins,** which you can redeem for rewards. Plus, you can earn financial incentives provided through a bank account deposit. Rally's digital experience gives you one place to track your activities and rewards.

To get started, go to **myuhc.com® > Health Resources > Rally.**

Health Actions	Reward
Complete the Health Survey and watch the video. The Health Survey takes about 15 minutes and upon completion, you'll receive personalized suggestions to help you set health goals. Pair this with a short Health Actions video to see your opportunities to earn rewards.	Rally Coins
Complete a Virtual Visit. Virtual Visits may be a convenient option when you need care. You can talk to a doctor—24/7—by phone or video for conditions like the flu, allergies, rashes, migraines and many more.	Rally Coins

*Earnings are per person and include covered spouse or domestic partner.

**Rally Coins can be earned under Rally Health. A reward can only be earned once per incentive year per health action, with the exception of the Fitness Action, up to the maximum incentive amount. Rally Coins may be used to enter sweepstakes for additional rewards.

continued

Health Actions	Reward
Complete a coaching program. The results of your Health Survey will provide recommendations for coaching programs that may help improve your health and wellness. These programs are available at no additional cost as part of your health plan benefits. Complete one of the following programs to earn more rewards: **Wellness Coaching** provides access to expert coaches and digital tools to help you reach your health goals. It's all about getting and staying healthy—your way—anytime. Choose from a variety of programs, like sleeping better, eating smarter and getting fit. **Real Appeal®** may help you start living a healthier life with online weight loss tools designed to help you achieve lifelong results, one small step at a time. Real Appeal provides the support to help you lose weight through online coaching, a Success Kit delivered to your door and a community of members to keep you motivated. **Quit For Life®** has helped 4 million enrollees quit smoking or using tobacco.[1] It provides the tools, 1-on-1 support and a personalized plan to help you quit your way.	Rally Coins
Complete Physical Activity Check-ins. Earn a Physical Activity Check-In reward by logging into the Rally Health mobile app or website and tracking compatible activity options. Check-in at least 12 days per month with a qualifying activity to earn a $20 monthly reward.	$20/mo. + Rally Coins

myuhc.com > Health Resources > Rally

[1] Quit For Life Employer Book of Business Survey results, cumulative from 2006 to 2018.

Real Appeal is a voluntary weight loss program that is offered to eligible participants as part of their benefit plan. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical and/or nutritional advice. Participants should consult an appropriate health care professional to determine what may be right for them. Any items/tools that are provided may be taxable and participants should consult an appropriate tax professional to determine any tax obligations they may have from receiving items/tools under the program.

Virtual Visits phone and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

The Quit For Life Program provides information regarding tobacco cessation methods and related well-being support. Any health information provided by you is kept confidential in accordance with the law. The Quit For Life Program does not provide clinical treatment or medical services and should not be considered a substitute for your doctor's care. Please discuss with your doctor how the information provided is right for you. Participation in this program is voluntary. If you have specific health care needs or questions, consult an appropriate health care professional. This service should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room.

UnitedHealthcare understands the importance of protecting your privacy. We care about the relationship we have with you. Our business practices are in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable privacy and security requirements.

Rally Health provides health and well-being information and support as part of your health plan. It does not provide medical advice or other health services, and is not a substitute for your doctor's care. If you have specific health care needs, consult an appropriate health care professional. Participation in the Health Survey is voluntary. Your responses will be kept confidential in accordance with the law and will only be used to provide health and wellness recommendations or conduct other plan activities.

SimplyEngaged® is a voluntary program. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult with an appropriate health care professional to determine what may be right for you. Rewards may be taxable. You should consult with an appropriate tax professional to determine if you have any tax obligations from receiving rewards under this program. If you are unable to meet a standard related to a health factor to obtain a reward under this program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 1-855-215-0230 and we will work with you (and, if necessary, your doctor) to find another way for you to earn the same reward.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

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Make your move with Apple Fitness+

Now included in your health plan

UnitedHealthcare is committed to providing a variety of health and wellness options, which is why we've added 12 months of Apple Fitness+ to your health plan—at no additional cost. Get ready for a different type of fitness experience with welcoming trainers who work hard to help bring out the best in you.

The first fitness service powered by Apple Watch

Your journey to a healthier body and mind starts here. Apple Fitness+ brings to life real-time fitness metrics from Apple Watch to your iPhone, iPad and Apple TV—and helps keep you motivated with:

- 11 workout types, ranging from HIIT to core to yoga
- New workouts added every week, lasting from 5 to 45 minutes
- Handpicked music from your favorite artists to help keep you going
- A subscription that can be shared with up to 5 family members

No additional cost

A $79.99 value*

(Apple Watch required)

Let's do this

Get started at **uhc.com/apple-fitness-plus**

*$9.99 per month for 12 months. Must be 13+ years of age and covered under applicable health plan.

Apple Fitness+ requires Apple Watch Series 3 or later with watchOS 7.2 or later and one of the following Apple devices: iPhone 6s or later with iOS 14.3 or later, iPad with iPadOS 14.3 or later, or Apple TV with tvOS 14.3 or later. Available to applicable UnitedHealthcare plans for fully insured customers who register for an account with Apple Fitness+. Subject to state legal and regulatory review.

All trademarks are the property of their respective owners.

The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult with an appropriate health care professional before beginning any exercise program and/or to determine what may be right for you. The value of the application may be taxable. You should consult with an appropriate tax professional to determine if you have any tax obligations from having access to this application at no additional cost. All trademarks are the property of their respective owners.

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For Option 2 and Option 3 Medical Plans

Visit with a doctor 24/7 — whenever, wherever

With 24/7 Virtual Visits, you can connect to a doctor by phone or video[1] through **myuhc.com**® or the UnitedHealthcare® app.

A convenient and faster way to get care

Doctors can treat a wide range of health conditions—including many of the same conditions as an emergency room (ER) or urgent care—and may even prescribe medications,[2] if needed. **With a UnitedHealthcare plan, your cost for a 24/7 Virtual Visit is usually $0.[3]**

Consider 24/7 Virtual Visits for these common conditions:

- Allergies
- Bronchitis
- Eye infections
- Flu
- Headaches/migraines
- Rashes
- Sore throats
- Stomachaches
- and more

$0 cost

An estimated 25% of ER visits could be treated with a 24/7 Virtual Visit—bringing a potential $2,000[4] cost down to $0.

Get started

Sign in at **myuhc.com/virtualvisits** | Call **1-855-615-8335**
Download the UnitedHealthcare app

United Healthcare

[1] Data rates may apply.

[2] Certain prescriptions may not be available, and other restrictions may apply.

[3] The Designated Virtual Visit Provider's reduced rate for a 24/7 Virtual Visit is subject to change at any time.

[4] Average allowed amounts charged by UnitedHealthcare Network Providers are not tied to a specific condition or treatment. Actual payments may vary depending upon benefit coverage. Estimated Urgent Care savings are based on the difference between average Urgent Care visit cost of $180 and Virtual Visit cost of $0; $2,000.00 difference between the average Emergency Room visit and the average urgent care visit. The information and estimates provided are for general informational and illustrative purposes only and is not intended to be nor should be construed as medical advice or a substitute for your doctor's care. You should consult with an appropriate health care professional to determine what may be right for you. In an emergency, call 911 or go to the nearest emergency room.

The UnitedHealthcare® app is available for download for iPhone® or Android®. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

24/7 Virtual Visits phone and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. 24/7 Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates. Health Plan coverage provided by or through a UnitedHealthcare company.

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For Option 1 Medical Plan

Visit with a doctor 24/7 — whenever, wherever

With 24/7 Virtual Visits, you can connect to a doctor by phone or video[1] through **myuhc.com®** or the UnitedHealthcare® app.

A convenient and faster way to get care

Doctors can treat a wide range of health conditions—including many of the same conditions as an emergency room (ER) or urgent care—and may even prescribe medications,[2] if needed. **With a UnitedHealthcare plan, your cost for a 24/7 Virtual Visit is usually $49 or less.[3]**

Consider 24/7 Virtual Visits for these common conditions:

- Allergies
- Bronchitis
- Eye infections
- Flu
- Headaches/migraines
- Rashes
- Sore throats
- Stomachaches
- and more

$49 cost

An estimated 25% of ER visits could be treated with a 24/7 Virtual Visit — bringing a potential $2,000[4] cost down to $49.

Get started

Sign in at **myuhc.com/virtualvisits** | Call **1-855-615-8335**
Download the UnitedHealthcare app

United Healthcare

[1] Data rates may apply.

[2] Certain prescriptions may not be available, and other restrictions may apply.

[3] The Designated Virtual Visit Provider's reduced rate for a 24/7 Virtual Visit is subject to change at any time.

[4] Average allowed amounts charged by UnitedHealthcare Network Providers are not tied to a specific condition or treatment. Actual payments may vary depending upon benefit coverage. Estimated Urgent Care savings are based on $131 difference between average Urgent Care visit cost of $180 and Virtual Visit cost of $49; $2,000.00 difference between the average Emergency Room visit and the average urgent care visit. The information and estimates provided are for general informational and illustrative purposes only and is not intended to be nor should be construed as medical advice or a substitute for your doctor's care. You should consult with an appropriate health care professional to determine what may be right for you. In an emergency, call 911 or go to the nearest emergency room.

The UnitedHealthcare® app is available for download for iPhone® or Android®. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

24/7 Virtual Visits phone and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. 24/7 Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates. Health Plan coverage provided by or through a UnitedHealthcare company.

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When life gets challenging, you've got caring, confidential help

Your Employee Assistance Program (EAP) provides support and resources to help you, and your family, with a range of issues, including:

- Managing stress, anxiety and depression
- Improving relationships at home or work
- Getting guidance on legal and financial concerns
- Coping with occupational stress and burnout support
- Addressing substance use issues

This service is provided to you at no additional cost.

Call today for access to EAP resources at no additional cost

EAP provides coverage for 3 free counseling sessions per incident, per year.

Services are completely confidential and will not be shared with your employer.

Get started – call EAP 24/7 at **1-888-887-4114**

United Healthcare

The material provided through this program is for informational purposes only. EAP staff cannot diagnose problems or suggest treatment. EAP is not a substitute for your doctor's care. Employees are encouraged to discuss with their doctor how the information provided may be right for them. Your health information is kept confidential in accordance with the law. EAP is not an insurance program and may be discontinued at any time. Due to the potential for a conflict of interest, legal consultation will not be provided on issues that may involve legal action against UnitedHealthcare or its affiliates, or any entity through which the caller is receiving these services directly or indirectly (e.g., employer or health plan). This program and its components may not be available in all states or for all group sizes and is subject to change. Coverage exclusions and limitations may apply.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

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Basic Life and Voluntary Insurance Plans through Guardian

All full time eligible employees are offered the opportunity to enroll in the Carrollton's Employer Paid Basic Life/AD&D plan offered by Guardian. The plan offers $20,000 of Basic Term Life coverage for all employees. See the summary that follows for more details.

All full time eligible employees are also offered the opportunity to enroll in the Carrollton's Voluntary Plans through Guardian. The plans include Voluntary Dental, Voluntary Vision and Voluntary Life. As stated, election of these coverages is voluntary and paid in full by you. The plans and rates are detailed on the following pages.

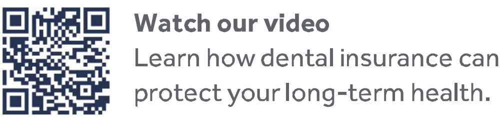
Who is Eligible and When:

- All full time eligible employees
  - Coverage begins 1st of the Month following date of hire
  - Coverage terms End of the Month

DENTAL – GUARDIAN *(BASE PLAN)*	***Monthly Rate***
Employee Only	$22.81
Employee + 1	$41.88
Family	$79.38

DENTAL – GUARDIAN *(BUY-UP PLAN)*	***Monthly Rate***
Employee Only	$51.26
Employee + 1	$94.12
Family	$136.73

VISION – GUARDIAN *(VSP/DAVIS)*	***Monthly Rate***
Employee Only	$9.51
Employee + 1	$13.61
Family	$24.65



Watch our video
Learn how dental insurance can protect your long-term health.

Dental insurance

Taking care of your teeth is about more than just covering cavities and cleanings. It also means accounting for more expensive dental work, and your overall health.

With dental insurance, routine preventive care can lead to better overall health. And you'll be able to save money if any extensive dental work is required.

Who is it for?

Everyone should have access to great dental coverage, which is why we offer comprehensive plans that are available through employers as part of your benefit offerings.

What does it cover?

Dental insurance helps to protect your overall oral care. That includes services like preventive cleanings, x-rays, restorative services like fillings, and other more serious forms of oral surgery if you ever need them.

Why should I consider it?

Poor oral health isn't just aesthetic, it's also been linked to conditions including diabetes, heart disease, and strokes. So, while brushing and flossing every day can help keep your teeth clean, nothing should replace regular visits to the dentist.

You will receive these benefits if you meet the conditions listed in the policy.

Staying healthy

Joe visits his dentist for a routine dental cleaning, to take care of his teeth as well as his overall health.

Oral health is about more than just teeth and gums. It's also essential for a range of other health and wellbeing reasons:

Cardiovascular disease: Some research suggests that heart disease, clogged arteries, and infections may be linked to inflammation and infections from oral bacteria.

Osteoporosis: Weak and brittle bones may be linked to tooth loss.

Diabetes: Research shows that people with gum disease find it more difficult to control their blood sugar levels.

Alzheimer's disease: Tooth loss before the age of 35 may be a risk factor for Alzheimer's disease.

All information contained here is from the Mayo Clinic, Oral Health: A Window to Your Overall Health, www.mayoclinic.com. 2018.

GUARDIAN® is a registered trademark of The Guardian Life Insurance Company of America

Your dental coverage

Option 1 or 2: PPO plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist. Out-of-network benefits are based on a percentile of the prevailing fee data for the dentist's zip code.

Your Dental Plan	Option 1: PPO		Option 2: PPO	
Your Network is	DentalGuard Preferred		DentalGuard Preferred	
Your Monthly premium	**$22.81**		**$51.26**	
You and 1 dependent (Spouse or Child)	$41.88		$94.12	
You, Spouse/Domestic Partner and Child(ren)	$79.38		$136.73	
Calendar year deductible	*In-Network*	*Out-of-Network*	*In-Network*	*Out-of-Network*
Individual	$50	$50	$50	$50
Family limit	3 per family		3 per family	
Waived for	Preventive	Preventive	Preventive	Preventive
Charges covered for you (co-insurance)	*In-Network*	*Out-of-Network*	*In-Network*	*Out-of-Network*
Preventive Care	80%	80%	100%	100%
Basic Care	70%	70%	80%	80%
Major Care	0%	0%	50%	50%
Orthodontia	Not Covered (applies to all levels)		50%	50%
Annual Maximum Benefit	$750		$1500	
Maximum Rollover	No		Yes	
Rollover Threshold			$700	
Rollover Amount			$350	
Rollover In-network Amount			$500	
Rollover Account Limit			$1250	
Lifetime Orthodontia Maximum	Not Applicable		$1000	
Dependent Age Limits(Non-Student/Student)	26/30 ‡		26/30 ‡	

‡**Family coverage** for spouse and children. The limiting age for unmarried dependents is extended to age 30 if the dependent is a resident of Illinois and has received a release or discharge, other than dishonorable discharge, from military service.

Your dental coverage

A Sample of Services Covered by Your Plan:

		Option 1: PPO *Plan pays (on average)*		**Option 2: PPO** *Plan pays (on average)*	
		In-network	*Out-of-network*	*In-network*	*Out-of-network*
Preventive Care	Cleaning (prophylaxis)	80%	80%	100%	100%
	Frequency:	Once Every 6 Months		Once Every 6 Months	
	Fluoride Treatments	80%	80%	100%	100%
	Limits:	Under Age 19		Under Age 19	
	Oral Exams	80%	80%	100%	100%
	Sealants (per tooth)	80%	80%	100%	100%
	X-rays	80%	80%	100%	100%
Basic Care	Anesthesia*	70%	70%	80%	80%
	Fillings‡	70%	70%	80%	80%
	Simple Extractions	70%	70%	80%	80%
Major Care	Bridges and Dentures	0%	0%	50%	50%
	Dental Implants	Not Covered	Not Covered	50%	50%
	Inlays, Onlays, Veneers**	0%	0%	50%	50%
	Perio Surgery	0%	0%	50%	50%
	Periodontal Maintenance	0%	0%	50%	50%
	Frequency:	Once Every 6 Months		Once Every 6 Months	
	Repair & Maintenance of Crowns, Bridges & Dentures	0%	0%	50%	50%
	Root Canal	0%	0%	50%	50%
	Scaling & Root Planing (per quadrant)	0%	0%	50%	50%
	Single Crowns	0%	0%	50%	50%
	Surgical Extractions	0%	0%	50%	50%
Orthodontia	Orthodontia	Not Covered		50%	50%
	Limits:			Child(ren)	

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. **For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filing material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age limit set by your plan; If full-time status is required by your plan in order to remain insured after a certain age; then orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for "Adults and Child(ren)" this limitation does not apply. *General Anesthesia – restrictions apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings.

Your dental coverage

Manage Your Benefits:	**Find A Dentist:**
Go to www.Guardianlife.com to access secure information about your Guardian benefits including access to an image of your ID Card. Your on-line account will be set up within 30 days after your plan effective date.	Visit www.Guardianlife.com Click on “Find A Provider”; You will need to know your plan, which can be found on the first page of your dental benefit summary.

EXCLUSIONS AND LIMITATIONS

Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred Network PPO plans: This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury. Deductibles apply. The plan does not pay for: oral hygiene services (except as covered under preventive services), orthodontia (unless expressly provided for), cosmetic or experimental treatments (unless they are expressly provided for), any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment. The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic, and prosthodontic services. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract # GP-1-DG2000 et al.

PPO and or Indemnity Special Limitation: Teeth lost or missing before a covered person becomes insured by this plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by this plan. We won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan. R3-DG2000

DentalGuard Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. This policy provides DENTAL insurance only.
Policy Form # GP-1-DG2000, et al, GP-1-DEN-16

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Oral Health Rewards Program

Regular visits to the dentist can help prevent and detect the early signs of serious diseases.

That's why Guardian's Maximum Rollover Oral Health Rewards Program encourages and rewards members who visit the dentist, by rolling over part of your unused annual maximum into a Maximum Rollover Account (MRA). This can be used in future years if your plan's annual maximum is reached.

Automatic rollover

Submit a claim (without exceeding the paid claims threshold of a benefit year), and Guardian will roll over a portion of your unused annual dental maximum.

How maximum rollover works*

Depending on a plan's annual maximum, if claims made for a certain year don't reach a specified threshold, then the set maximum rollover amount can be rolled over.

Plan annual maximum**	Threshold	Maximum rollover amount	In-network only rollover amount	Maximum rollover account limit
$1,500 Maximum claims reimbursement	**$700** Claims amount that determines rollover eligibility	**$350** Additional dollars added to a plan's annual maximum for future years	**$500** Additional dollars added if only in-network providers were used during the benefit year	**$1,250** The limit that cannot be exceeded within the maximum rollover account

* This example has been created for illustrative purposes only.

** If a plan has a different annual maximum for PPO benefits vs. non-PPO benefits, ($1500 PPO/$1000 non-PPO for example) the non-PPO maximum determines the Maximum Rollover plan. May not be available in all states.

Guardian's Dental Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. Information provided in this communication is for informational purposes only. Dental Policy Form No. GP-1-DEN-16. GUARDIAN® is a registered service mark of The Guardian Life Insurance Company of America ® ©Copyright 2019 The Guardian Life Insurance Company of America.

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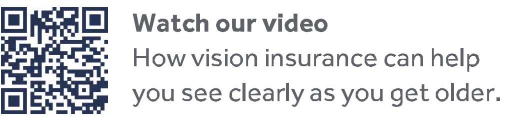
2020-105050 (07/22)



Watch our video
How vision insurance can help you see clearly as you get older.

Vision insurance

Vision insurance helps protect the health of your eyes by providing coverage for benefits that often aren't covered by regular medical insurance.

Protecting your eyesight means allowing for routine visits to the optometrist for eye exams, as well as coverage for glasses and contacts. Make sure your eyes remain in great shape at any age – no matter how much time you spend staring at digital screens.

Who is it for?

Even if you have perfect eyesight, it's important to have regular eye exams to make sure you're still seeing clearly. Most of us may eventually need vision correction, which is why we offer vision insurance to cover some of the costs.

What does it cover?

Vision insurance covers benefits not typically included in medical insurance plans. It covers things like routine eye exams, allowances towards the purchase of eyeglasses and contact lenses, as well as discounts on corrective Lasik surgery.

Why should I consider it?

Regular eye exams can detect more than failing eyesight, they can also pick up diseases like glaucoma and diabetes. Vision problems are one of the most prevalent disabilities in the United States, making vision insurance especially useful for anyone who regularly needs to purchase eyeglasses or contacts, or anyone who simply wants to help protect their eyesight and general health.

You will receive these benefits if you meet the conditions listed in the policy.

20/20 coverage

David notices that his vision is deteriorating. He goes in for an eye exam, and is diagnosed with myopia, which means he needs glasses.

Average cost of vision exam: **$171**

Average cost of frames and lenses: **$350**

Total cost: **$521**

With a Vision policy from Guardian, David pays just **$10** for his eye exam. After **$25** in copay, his lenses are fully covered, and he pays **$96** for his frames.

David's total out-of-pocket expense is **$131**, saving him **$390**.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.

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Your vision coverage

Option 1: Significant out-of-pocket savings available with your **Full Feature** plan by visiting one of VSP's network locations.

Option 2: Significant out-of-pocket savings available with your **Full Feature** plan by visiting one of Davis Vision's network locations including retail centers such as Costco®, Wal-Mart®, JCPenney®, Target®, Sam's Club®, Pearle®, Visionworks®. You can also use your network benefits online at Visionworks®.com, glasses®.com, or 1800contacts®.com.

Your Vision Plan	Option 1: Full Feature		Option 2: Full Feature - Designer	
Your Network is	VSP Choice Network		Davis Vision	
Your Monthly premium	**$ 9.51**		**$ 9.51**	
You and 1 dependent	$ 13.61		$ 13.61	
You, Spouse/Domestic partner and Child(ren)	$ 24.65		$ 24.65	
Copay				
Exams Copay	$ 10		$ 10	
Materials Copay *(waived for elective contact lenses)*	$ 20		$ 20	
Sample of Covered Services	*You pay (after copay if applicable):*		*You pay (after copay if applicable):*	
	In-network	*Out-of-network*	*In-network*	*Out-of-network*
Eye Exams	$0	Amount over $39	$0	Amount over $50
Single Vision Lenses	$0	Amount over $23	$0	Amount over $48
Lined Bifocal Lenses	$0	Amount over $37	$0	Amount over $67
Lined Trifocal Lenses	$0	Amount over $49	$0	Amount over $86
Lenticular Lenses	$0	Amount over $64	$0	Amount over $126
Frames	80% of amount over $130[1]	Amount over $46	80% of amount over $130*[2]	Amount over $48
Contact Lenses *(Elective)*	Amount over $130	Amount over $100	N/A	N/A
Contact Lenses *(Elective and conventional)*	N/A	N/A	85% of amount over $130*	Amount over $105
Contact Lenses *(Planned replacement and disposable)*	N/A	N/A	85% of amount over $130*	Amount over $105
Contact Lenses *(Medically Necessary)*	$0	Amount over $210	$0	Amount over $210
Contact Lenses *(Evaluation and fitting)*	15% off UCR	No discounts	No discounts	No discounts
Cosmetic Extras	Avg. 20-25% off retail price	No discounts	Avg. 40-60% off retail price	No discounts
Glasses *(Additional pair of frames and lenses)*	20% off retail price**	No discounts	50% at Visionworks and 30% at other in network providers	No discounts
Laser Correction Surgery Discount	Up to 15% off the usual charge or 5% off promotional price	No discounts	Savings of 40-50% off national average price thru Davis laser vision network	No discounts
Service Frequencies				
Exams	Every calendar year		Every calendar year	

Your vision coverage

Your Vision Plan	Option 1: Full Feature	Option 2: Full Feature - Designer
Lenses *(for glasses or contact lenses)*‡‡	Every calendar year	Every calendar year
Frames	Every two calendar years‡‡‡	Every two calendar years
Network discounts *(glasses and contact lens professional service)*	Limitless within 12 months of exam.	Applies to first purchase & courtesy discount from most providers on subsequent purchases.
Dependent Age Limits (Non-Student/ Student)	26/30	26/30

Visit www.Guardianlife.com and click on "Find a Provider"

VSP

- ‡‡Benefit includes coverage for glasses or contact lenses, not both.
- Family coverage for spouse and children. The limiting age for unmarried dependents is extended to age 30 if the dependent is a resident of Illinois and has received a release or discharge, other than dishonorable discharge, from military service.
- ** For the discount to apply your purchase must be made within 12 months of the eye exam.
- Charges for an initial purchase can be used toward the material allowance. Any unused balance remaining after the initial purchase cannot be banked for future use. The only exception would be if a member purchases contact lenses from an out of network provider, members can use the balance towards additional contact lenses within the same benefit period.
- [1]Extra $20 on select brands
- Members can use their in network benefits on line at Eyeconic.com.
- *‡‡‡.The VSP system considers contact lenses to be the equivalent of a full pair of eyeglasses (lenses and frames) so while the member can obtain contact lenses one year and standard eyeglass lenses the next year, the frames benefit would not be available until 24 months or two calendar years, depending on the plan design, after the date the member obtained the contact lenses.*
- In Network Routine Retinal Screening Covered after no more than a $39 copay.

Davis

- ‡‡Benefit includes coverage for glasses or contact lenses, not both.
- Family coverage for spouse and children. The limiting age for unmarried dependents is extended to age 30 if the dependent is a resident of Illinois and has received a release or discharge, other than dishonorable discharge, from military service.
- Contact lenses from Davis Vision's Collection are available at most private practice locations with Full Feature and Materials Only plans. Contacts from the collection are covered in full including fitting and evaluation, in excess of the plan's materials copay. Elective contacts that are not part of the Collection are covered up to the plan's elective contact lens allowance and the materials copay is waived.
- *Additional discounts are not available at all private practice locations. Costco, Walmart, Sam's Club, glasses.com, and 1800contacts.com do not allow additional discounts.
- For Davis Vision, complete eyeglasses must be purchased at one time from one provider. For example, if a member purchases only lenses, he or she cannot purchase frames later in the same benefit period. The member is not eligible for new vision materials until the next benefit period. Only charges for an initial purchase can be used toward the material allowance. Any unused balance remaining after the initial purchase cannot be banked for future use.
- [2]Extra $50 at Visionworks stores and at Visionworks.com.
- In Network Routine Retinal Screening Covered after no more than a $39 copay.

Your vision coverage

EXCLUSIONS AND LIMITATIONS

Important Information: This policy provides vision care limited benefits health insurance only. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department. Coverage is limited to those charges that are necessary for a routine vision examination. Co-pays apply. The plan does not pay for: orthoptics or vision training and any associated supplemental testing; medical or surgical treatment of the eye; and eye examination or corrective eyewear required by an employer as a condition of employment; replacement of lenses and frames that are furnished under this plan, which are lost or broken (except at normal intervals when services are otherwise available or a warranty exists). The plan limits benefits for blended lenses, oversized lenses, photochromic lenses, tinted lenses, progressive multifocal lenses, coated or laminated lenses, a frame that exceeds plan allowance, cosmetic lenses; U-V protected lenses and optional cosmetic processes.

The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract #GP-1-DAVIS-05-VIS et al. Contract #GP-1-VSN-96-VIS et al.

Laser Correction Surgery:

Laser surgery is not an insured benefit. The surgery is available at a discounted fee. The covered person must pay the entire discounted fee. In addition, the laser surgery discount may not be available in all states.

Guardian's Vision Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. This policy provides vision care limited benefits health insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services. Plan documents are the final arbiter of coverage.
Policy Form # GP-1-GVSN-17

GUARDIAN® is a registered trademark of The Guardian Life Insurance Company of America

Watch our video
How life insurance protects families and covers critical costs.

Life insurance

If something happens to you, life insurance can help your family reduce financial stress.

Life insurance helps protect your family's finances by providing a cash benefit if you pass away. This ensures that they'll be financially supported, and can cover important things from bills to funeral costs. With life policies, you can get affordable life insurance protection for a set period of time.

Who is it for?

Everyone's life insurance needs are different, depending on their family situation. That's why group life insurance through an employer is an easier and more affordable option than individual life insurance.

What does it cover?

Life insurance protects your loved ones by providing a benefit (which is usually tax-exempt) if you pass away.

Why should I consider it?

Life insurance is about more than just covering expenses. Depending on your circumstances, it could take your family years to recover from the loss of your income.

With a life insurance benefit, your family will have extra money to cover mortgage and rent payments, legal or medical fees, childcare, tuition, and any outstanding debts.

Guardian, its subsidiaries, agents, and employees do not provide tax, legal, or accounting advice. Consult your tax, legal, or accounting professional regarding your individual situation.

You will receive these benefits if you meet the conditions listed in the policy.

Preparing and planning

Jorge's never considered purchasing life insurance, but after being offered it through work, he decides it's a smart way to protect his family.

Jorge has a mortgage, and because his wife is helping to take care of her mother, she only works part-time. In addition, his daughter is about to start college.

Jorge looks at how his family would be affected by losing him.

Average funeral cost: **$9,000**

Average mortgage debt: **$202,000**

Average cost of college: **$17,000 - $44,000**

Average household credit card debt: **$8,500**

With life insurance, Jorge can make sure that part of these costs are covered if something happens to him.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.

GUARDIAN® is a registered trademark of The Guardian Life Insurance Company of America

Your life coverage

	BASIC LIFE	VOLUNTARY TERM LIFE
Employee Benefit	Your employer provides $20,000 Basic Term Life coverage for all full time employees.	Choice of 6 employer-specified amounts, from $10,000 to $150,000. See Cost Illustration page for details.
Accidental Death and Dismemberment	Your Basic Life coverage includes Accidental Death and Dismemberment coverage.	Employee, Spouse & Child(ren) coverage. Maximum 1 times life amount.
Spouse/Domestic Partner Benefit	N/A	$5,000 increments to a maximum of $75,000. See Cost Illustration page for details.‡
Child Benefit	N/A	Your dependent children age 14 days to 26 years. $5,000 increments to a maximum of $10,000. Subject to state limits. See Cost Illustration page for details.
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when you sign up for coverage during the initial enrollment period.	Guarantee Issue coverage up to $20,000 per employee	We Guarantee Issue coverage up to: Employee Less than age 65 $150,000, 65-69 $50,000, 70+ $10,000. Spouse Less than age 65 $50,000, 65-69 $10,000, $0. Dependent children $10,000.
Premiums	Covered by your company if you meet eligibility requirements	Increase on plan anniversary after you enter next five-year age group
Portability: Allows you to take coverage with you if you terminate employment.	Yes, with age and other restrictions, including evidence of insurability	Yes, with age and other restrictions

Your life coverage

	BASIC LIFE	VOLUNTARY TERM LIFE
Conversion: Allows you to continue your coverage after your group plan has terminated.	Yes, with restrictions; see certificate of benefits	Yes, with restrictions; see certificate of benefits
Accelerated Life Benefit: A lump sum benefit is paid to you if you are diagnosed with a terminal condition, as defined by the plan.	No	Yes
Waiver of Premiums: Premium will not need to be paid if you are totally disabled.	For employees disabled prior to age 60, with premiums waived until age 65, if conditions are met	For employees disabled prior to age 60, with premiums waived until age 65, if conditions met
Benefit Reductions: Benefits are reduced by a certain percentage as an employee ages.	35% at age 65, 60% at age 70, 75% at age 75, 85% at age 80	35% at age 65, 60% at age 70, 75% at age 75, 85% at age 80

Subject to coverage limits

‡ **Spouse/DP coverage terminates at age 70.**

Voluntary Life Cost Illustration:

To determine the most appropriate level of coverage, as a rule of thumb, you should consider about 6 - 10 times your annual income, factoring in projected costs to help maintain your family's current life style.

Monthly premiums displayed. Cost of AD&D is included.

Policy Election Amount	**Policy Election Cost Per Age Bracket**								
Employee	**< 30**	**30–34**	**35–39**	**40–44**	**45–49**	**50–54**	**55–59**	**60–64**	**65–69†**
$10,000	$.85	$1.05	$1.35	$1.95	$3.05	$4.95	$7.95	$9.85	$16.85
$25,000	$2.13	$2.63	$3.38	$4.88	$7.63	$12.38	$19.88	$24.63	$42.13
$50,000	$4.25	$5.25	$6.75	$9.75	$15.25	$24.75	$39.75	$49.25	$84.25
$75,000	$6.38	$7.88	$10.13	$14.63	$22.88	$37.13	$59.63	$73.88	$126.38
$100,000	$8.50	$10.50	$13.50	$19.50	$30.50	$49.50	$79.50	$98.50	$168.50
$150,000	$12.75	$15.75	$20.25	$29.25	$45.75	$74.25	$119.25	$147.75	$252.75
Policy Election Amount									
Spouse/DP									
$5,000	$.43	$.53	$.68	$.98	$1.53	$2.48	$3.98	$4.93	$8.43
$10,000	$.85	$1.05	$1.35	$1.95	$3.05	$4.95	$7.95	$9.85	$16.85
$15,000	$1.28	$1.58	$2.03	$2.93	$4.58	$7.43	$11.93	$14.78	$25.28
$20,000	$1.70	$2.10	$2.70	$3.90	$6.10	$9.90	$15.90	$19.70	$33.70
$25,000	$2.13	$2.63	$3.38	$4.88	$7.63	$12.38	$19.88	$24.63	$42.13
$30,000	$2.55	$3.15	$4.05	$5.85	$9.15	$14.85	$23.85	$29.55	$50.55
$35,000	$2.98	$3.68	$4.73	$6.83	$10.68	$17.33	$27.83	$34.48	$58.98
$40,000	$3.40	$4.20	$5.40	$7.80	$12.20	$19.80	$31.80	$39.40	$67.40
$45,000	$3.83	$4.73	$6.08	$8.78	$13.73	$22.28	$35.78	$44.33	$75.83
$50,000	$4.25	$5.25	$6.75	$9.75	$15.25	$24.75	$39.75	$49.25	$84.25
$55,000	$4.68	$5.78	$7.43	$10.73	$16.78	$27.23	$43.73	$54.18	$92.68
$60,000	$5.10	$6.30	$8.10	$11.70	$18.30	$29.70	$47.70	$59.10	$101.10
$65,000	$5.53	$6.83	$8.78	$12.68	$19.83	$32.18	$51.68	$64.03	$109.53
$70,000	$5.95	$7.35	$9.45	$13.65	$21.35	$34.65	$55.65	$68.95	$117.95
$75,000	$6.38	$7.88	$10.13	$14.63	$22.88	$37.13	$59.63	$73.88	$126.38
Policy Election Amount									
Child(ren)									
$5,000	$0.47	$0.47	$0.47	$0.47	$0.47	$0.47	$0.47	$0.47	$0.47
$10,000	$0.94	$0.94	$0.94	$0.94	$0.94	$0.94	$0.94	$0.94	$0.94

Refer to Guarantee Issue row on page above for Voluntary Life GI amounts.
Premiums for Voluntary Life Increase in five-year increments
Spouse/DP coverage premium is based on Employee age.
†Benefit reductions apply.

LIMITATIONS AND EXCLUSIONS:

A SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS FOR LIFE AND AD&D COVERAGE:

You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period. Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations. Evidence of Insurability is required on all late enrollees. This coverage will not be effective until approved by a Guardian underwriter. This proposal is hedged subject to satisfactory financial evaluation. Please refer to certificate of coverage for full plan description.

Dependent life insurance will not take effect if a dependent, other than a newborn, is confined to the hospital or other health care facility or is unable to perform the normal activities of someone of like age and sex.

Accelerated Life Benefit is not paid to an employee under the following circumstances: one who is required by law to use the benefit to pay creditors; is required by court order to pay the benefit to another person; is required by a government agency to use the payment to receive a government benefit; or loses his or her group coverage before an accelerated benefit is paid.

Voluntary Life Only:

We pay no benefits if the insured's death is due to suicide within two years from the insured's original effective date. This two year limitation also applies to any increase in benefit. This exclusion may vary according to state law. Late entrants and benefit increases require underwriting approval.

GP-1-R-LB-90, GP-1-R-EOPT-96

Guarantee Issue/Conditional Issue amounts may vary based on age and case size. See your Plan Administrator for details. Late entrants and benefit increases require underwriting approval.

For AD&D: We pay no benefits for any loss caused: by willful self-injury; sickness, disease or medical treatment; by participating in a civil disorder or committing a felony; Traveling on any type of aircraft while having duties on that aircraft; by declared or undeclared act of war or armed aggression; while a member of any armed force (May vary by state); while driving a motor vehicle without a current, valid driver's license; by legal intoxication; or by voluntarily using a non-prescription controlled substance. Contract #GP-1-R-ADCL1-00 et al. We won't pay more than 100% of the Insurance amount for all losses due to the same accident, except as stated. The loss must occur within a specified period of time of the accident. Please see contract for specific definition; definition of loss may vary depending on the benefit payable.

Guardian Group Life Insurance underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage.
Policy Form # GP-1-LIFE-15

WillPrep

Protect the ones you love with a range of dedicated services designed to help you provide for your family.

WillPrep Services includes a range of different resources that make it easier for you to prepare a will.

These range from a library of online planning documents to accessing experienced professionals that can help you with the more complicated details.

How it can help

Access simple documents including wills and power of attorney letters

Speak with consultants to discuss estate planning

Prepare your will with the assistance or support of an attorney

How to access

To access WillPrep Services, you'll need a few personal details.

Visit
willprep.uprisehealth.com

Username
WillPrep

Password
GLIC09

For more information or support, you can reach out by phoning **1 877 433 6789**.

This service is only available if you purchase qualifying lines of coverage. See your plan administrator for more details.

WillPrep Services are provided by Uprise Health, and its contractors. The Guardian Life Insurance Company of America (Guardian) does not provide any part of Will Prep Services. Guardian is not responsible or liable for care or advice given by any provider or resource under the program. This information is for illustrative purposes only. It is not a contract. Only the Administration Agreement can provide the actual terms, services, limitations and exclusions. Guardian and Uprise Health reserve the right to discontinue the WillPrep Services at any time without notice. Legal services will not be provided in connection with or preparation for any action against Guardian, Uprise Health, or your employer.

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2020-104979 (07/22)

Employee Assistance Program

We all need a little support every now and then.

Guardian's Employee Assistance Program gives you and your family members access to confidential personal support, across everything from stress management and nutrition to handling legal or financial issues.

The services available include consultations with experienced professionals, as well as access to resources and discounts designed to help you in a variety of different ways.

How it can help

Consultative services are available to provide direct support and assistance

Work/life assistance that can help you save money and balance commitments

Access legal and financial assistance and resources – including WillPrep Services

How to access

To access the WorkLifeMatters Employee Assistance Program, you'll need a few personal details.

Visit
worklife.uprisehealth.com

Access Code
worklife

For more information or support, you can reach out by phoning **1 800 386 7055**. The team is available 24 hours a day, 7 days a week[1].

This service is only available if you purchase qualifying lines of coverage. See your plan administrator for more details.

WorkLifeMatters Program services are provided by Uprise Health, and its contractors. Guardian does not provide any part of WorkLifeMatters program services. Guardian is not responsible or liable for care or advice given by any provider or resource under the program. This information is for illustrative purposes only. It is not a contract. Only the Administration Agreement can provide the actual terms, services, limitations and exclusions. Guardian and Uprise Health reserve the right to discontinue the WorkLifeMatters program at any time without notice. Legal services provided through WorkLifeMatters will not be provided in connection with or preparation for any action against Guardian, Uprise Health, or your employer. WorkLifeMatters Program is not an insurance benefit and may not be available in all states.

[1]Office hours: Monday-Friday 6 a.m.–5 p.m. PST.

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2021-117403 (3/23)

Enrollment Forms

NOTE: It is very important that you complete and submit your enrollment forms within the required timeframe. If you do not complete your enrollment forms by the deadline, you will, by default, waive your rights to the company group benefits.

Eligibility

If you are a new hire, you will become eligible for coverage the 1st of the month following your date of hire.

This will be the date on which your coverage becomes available. You may complete your enrollment forms/applications any time before this date, but you must complete the forms within 31 days of the effective date. If you do not submit your enrollment forms within the time frame above, you must wait until the next annual open enrollment to make your benefit elections.

Who can be added to your plan:

- Legally married spouse
- Natural or adopted children under 26 years old
- Children under your legal guardianship / Stepchildren
- Children under a qualified medical child support order and disabled children 26 years or older
- Children placed in your physical custody for adoption

NOTE: **After your initial eligibility period, you cannot make changes to your coverage until the next open enrollment period, unless you experience a qualifying event, such as:**

- Loss or gain of coverage through your spouse
- Loss of eligibility of a covered dependent
- Death of your covered spouse or child
- Birth or adoption of a child
- Marriage, divorce, or legal separation
- Switch from part-time to full-time

You have **30 days** from a change in family status to make changes to your current coverage.

www.assuredpartners.com

Ashley Peterson

ashley.peterson@assuredpartners.com 618.391.1046

Group Medical Insurance Waiver

Carrollton CUSD #1

I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer.

I understand and agree:

If I am declining coverage for myself, my spouse/domestic partner, or my dependent child(ren) because of other coverage, I may in the future be able to enroll myself, my spouse/domestic partner, or my dependent child(ren) provided that I request enrollment within 31 days after the other coverage ends.

If I have a new spouse/domestic partner or child as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my new spouse/domestic partner or child provided that I request enrollment within 31 days after the marriage, birth, adoption, or placement of adoption.

If I decide to request coverage in the future, for a reason other than the termination of other coverage or the addition of a new spouse/domestic partner or child. I may be considered a late enrollee, if applicable, or I may have to wait until the plan's next open enrollment period. I also understand that as a late enrollee, coverage for preexisting conditions may be excluded for up to a period of 18 months. This period may be offset by the time I, my spouse/domestic partner, or my dependent child(ren) was covered under a qualified health plan.

I certify that I was not pressured, forced, or unfairly induced by my employer, the agent, or the insurer(s) into waiving or declining the group coverage.

I certify that I understand **Carrollton CUSD #1** group medical plan meets all minimum standards of the Affordable Care Act. By waiving coverage I acknowledge that I may not be eligible for a subsidy on any exchange.

I ______________________________________DO NOT WANT, AND HERBY WAIVE MEDICAL COVERAGE.

PRINT NAME

SIGNATURE: ____ DATE:____________________

Carrollton CUSD #1

Benefits Election Form – Enrollment – NON CERTIFIED EMPLOYEES

Employee Name (please print)____

Medical Insurance – United Healthcare (UHC)

I elect the following insurance coverage: MONTHLY COST

Plan 1 – *H.S.A Plan $1,500 deductible*	**Plan 2 – *Traditional PPO $3,000 deductible***
☐ Employee only - $56.66 ☐ Employee & Spouse - $804.60 ☐ Employee & Child(ren) - $658.38 ☐ Family - $1,406.32	☐ Employee only - $87.13 ☐ Employee & Spouse - $876.47 ☐ Employee & Child(ren) - $722.15 ☐ Family - $1,511.49
Plan 3 – *Traditional PPO $1,500 deductible* ☐ Employee only - $120.12 ☐ Employee & Spouse - $954.29 ☐ Employee & Child(ren) - $791.21 ☐ Family - $1,625.38	☐ **Waive – NO MEDICAL COVERAGE** I acknowledge I was offered an employer sponsored group health plan that meets the Affordable Care Act's affordability and minimum value requirements, but I choose not to participate in the medical plan. By waiving I acknowledge that I may not be eligible for a subsidy on any private exchange plan.

Dental & Vision Insurance – Guardian

I elect the following insurance coverage: MONTHLY COST

DENTAL PLAN - BASE	**DENTAL PLAN – BUY-UP**
☐ Employee only - $22.81 ☐ Employee + 1 - $41.88 ☐ Family - $79.38 ☐ WAIVE – I decline Dental (BASE) Coverage	☐ Employee only - $51.26 ☐ Employee + 1 - $94.12 ☐ Family - $136.73 ☐ WAIVE – I decline Dental (BUY-UP) Coverage

VISION PLAN (VSP)	**VISION PLAN (DAVIS)**
☐ Employee only - $9.51 ☐ Employee + 1 - $13.61 ☐ Family - $24.65	☐ Employee only - $9.51 ☐ Employee + 1 - $13.61 ☐ Family - $24.65
☐ WAIVE – I decline Vision Coverage	

Life Insurance – Guardian

BASIC LIFE & AD&D	**This life insurance is <u>optional</u> and will be a deduction pending on which option(s) are selected. See Rate Sheet**
☒ $20,000 Policy Provided by the District at no cost **NOTE:** **For employees that work 30 or more hours per week.**	**VOLUNTARY LIFE INSURANCE –** ***Rates based on Employee Age See Guardian Chart*** **WAIVE – NO COVERAGE** ☐ I decline all voluntary life coverage. I understand that I may be required to complete a health statement to enroll at a later time.

Acknowledgement & Signature: I understand the coverage I have elected is effective 1st of the month following date of hire

Date _______________ ***Signature*** ____________________________________

CARROLLTON CUSD #1 - 2022/2023 SCHOOL YEAR

MEDICAL PLANS COMPARISON - UNITED HEALTHCARE

	PLAN 1 AEZ1 - H.S.A / 2V H.S.A	PLAN 2 BT4Y (Balanced) / 2V PPO	PLAN 3 BT4V (Balanced) / 2V PPO
DEDUCTIBLE (SINGLE / FAMILY)	$1,500 / $4,500	$3,000 / $6,000	$1,500 / $3,000
COINSURANCE	80%	80%	80%
MEDICAL OUT OF POCKET LIMIT (S/F)	$5,000 / $6,850	$6,250 / $12,500	$6,250 / $12,500
OUT OF POCKET LIMIT	*OOP - INCLUDES ALL DED, COINS, COPAYS*		
PREVENTATIVE SERVICES (NO DEDUCTIBLE)	100%	100%	100%
COPAYS			
PRIMARY DOCTOR	Ded/Coins	$35 , <19 $0	$35 , <19 $0
SPECIALIST	Ded/Coins	$70	$70
VIRTUAL VISIT (PPO Plans Only)	Ded/Coins	$0	$0
Major Diagnostics (PET scan, MRI,)	Ded/Coins	$400 copay	$400 Copay
EMERGENCY ROOM	Ded/Coins	Ded/Coins	Ded/Coins
URGENT CARE	Ded/Coins	$50	$50
PRESCRIPTION COPAYS	*(After Deductible is met)*		
TIER 1	$10	$10	$10
TIER 2	$35	$35	$35
TIER 3	$60	$60	$60

DENTAL PLANS COMPARISON - GUARDIAN

	BASE PLAN		**BUY-UP PLAN**	
DEDUCTIBLE (SINGLE / FAMILY)	$50/$150		$50/$150	
Waived for	Preventative		Preventative	
Charges covered for you (co-insurance)	In-Network	Out-of-Network	In-Network	Out-of-Network
Preventative Care	80%	80%	100%	100%
Basic Care	70%	70%	80%	80%
Major Care	0%	0%	50%	50%
	-	-	50%	50%
Annual Maximum Benefit	$750		$1,500	
Lifetime Orthodontia Maximum	-		$1,000	

VISION PLANS COMPARISON - GUARDIAN

	VSP	**DAVIS**
Exam Copay	$10	$10
Materials Copay	$20	$20
Service Frequencies		
Exams	Every Calendar Year	Every Calendar Year
Lenses (glasses or contacts)	Every Calendar Year	Every Calendar Year
Frames	Every two Calendar Years	Every two Calendar Years

Enrollment Application/Change/Cancellation Request

Illinois

- ☐ UnitedHealthcare Insurance Company
- ☐ UnitedHealthcare Insurance Company of Illinois
- ☐ UnitedHealthcare of Illinois, Inc.
- ☐ UnitedHealthcare Insurance Company of the River Valley
- ☐ UnitedHealthcare Plan of the River Valley, Inc.

☐ **Enroll** ☐ **Cancel** ☐ **Change**

☐ **Address Change** ☐ **Name Change** **Date of Change**____ /___ /____

To Be Completed By Employer

ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of application, 1) please review all sections and confirm the employee completed the appropriate information, 2) complete the information in this section and 3) provide your signature and today's date. If the employee is waiving coverage, do not submit the application but retain it for your records.

Company Name	Group #	Department #

Plan Variation	Reporting Code	Benefit Level/Class Code, if applicable
Medical ______ Vision ______	Medical ______ Vision ______	Life/AD&D ______ Suppl. Life ______
Dental ______ Life ______	Dental ______ Life ______	Spouse Life ______ Suppl. AD&D ______

☐ **New Enrollment/Additions: (Check one)**
Date of Hire ___ /___ /___ Requested Date of Coverage ___ /___ /___
- ☐ New Hire ☐ Status Change (PT to FT)
- ☐ Return from Leave/Layoff
- ☐ Birth ☐ Marriage ☐ Adoption
- ☐ Court ordered dependent
- ☐ Other (describe) ________________________

☐ COBRA/State Continuation start date _______ stop date________
☐ **Annual Open Enrollment** Requested Effective Date of Enrollment ___ /__ /___

☐ **Cancellations:** Last Date of Employment ___ /___ /___
Requested Effective Date of Cancellation ___ /___ /___
- ☐ Cancel all coverage
- ☐ Cancel all listed below – Section B

Reason: (check one)
- ☐ Death ☐ Employee Terminated ☐ Divorce
- ☐ Moved out of service area
- ☐ Dependent reached dependent max age
- ☐ Other (describe)____________________________

Employee Type			
☐ Union ☐ Non-union	☐ Salaried ☐ Hourly	☐ Active ☐ COBRA/State Cont. ☐ Retire Date ___________	#Hours worked per week _________

Signature ____ Date ___________________

Employer Position______________________________ Phone Number_________________________

A. Employee Information

Last Name	First Name	MI	Social Security Number
			_ _ _ – _ _ – _ _ _ _

Address	Apt #	City	State	Zip Code	Home/Cell Phone

Date of Birth	Sex	Marital Status	Work Phone
/ /	☐ M ☐ F	☐ Single ☐ Divorced ☐ Married ☐ Widowed	

Email Address

Language Preference, if not English

Race – Check all that apply (Optional)[2]
- ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American
- ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White
- ☐ Other–Please specify ___________________________________

Primary Physician[1]	Primary Dentist[1]
Physician First & Last Name ___________________________________	Dentist First & Last Name ___________________________________
ID # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ - ___ ___ ___ ___	ID# ____

[1]IMPORTANT: Please see employer representative as some plans require a Primary Physician (Primary Care) and/or a Primary Care Dentist (PCD) selection.

[2]Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination.

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of Illinois, UnitedHealthcare of Illinois, Inc., UnitedHealthcare Insurance Company of the River Valley, or UnitedHealthcare Plan of the River Valley, Inc.
Dental coverage provided by UnitedHealthcare Insurance Company or Dental Benefit Providers of Illinois, Inc.
Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company

B. Family Information

List All Enrolling/Changing/Cancelling (Attach sheet if necessary)

Check appropriate box	Relationship[2]	Last Name	First Name	MI	Sex	Date of Birth
☐ Enroll ☐ Cancel ☐ Change	Spouse /Domestic Partner				☐ M ☐ F	_____ /_____ /_______
		Social Security Number: ___ ___ ___ – ___ ___ – ___ ___ ___ ___		Primary Physician[1] Name: ______ ID# ______ - ____		
Race – Check all that apply (Optional)[3]	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify ______			Primary Care Dentist[1] Name: ______ ID# ______		

Check appropriate box	Relationship[2]	Last Name	First Name	MI	Sex	Date of Birth
☐ Enroll ☐ Cancel ☐ Change	Dependent				☐ M ☐ F	_____ /_____ /_______
		Social Security Number: ___ ___ ___ – ___ ___ – ___ ___ ___ ___		Primary Physician[1] Name: ______ ID# ______ - ____		
Race – Check all that apply (Optional)[3]	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify ______			Primary Care Dentist[1] Name: ______ ID# ______		

Check appropriate box	Relationship[2]	Last Name	First Name	MI	Sex	Date of Birth
☐ Enroll ☐ Cancel ☐ Change	Dependent				☐ M ☐ F	_____ /_____ /_______
		Social Security Number: ___ ___ ___ – ___ ___ – ___ ___ ___ ___		Primary Physician[1] Name: ______ ID# ______ - ____		
Race – Check all that apply (Optional)[3]	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify ______			Primary Care Dentist[1] Name: ______ ID# ______		

Check appropriate box	Relationship[2]	Last Name	First Name	MI	Sex	Date of Birth
☐ Enroll ☐ Cancel ☐ Change	Dependent				☐ M ☐ F	_____ /_____ /_______
		Social Security Number: ___ ___ ___ – ___ ___ – ___ ___ ___ ___		Primary Physician[1] Name: ______ ID# ______ - ____		
Race – Check all that apply (Optional)[3]	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify ______			Primary Care Dentist[1] Name: ______ ID# ______		

[1]IMPORTANT: Please see employer representative as some plans require a Primary Physician (Primary Care) and/or a Primary Care Dentist (PCD) selection.
[2]For some cases, such as Qualified Medical Child Support, additional documentation may be required. Please see employer representative for more information.
[3]Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination.

C. Product Selection

Please check the box for each coverage in which you or your dependents are enrolling.
If your employer offers a choice of plans, indicate which plan you are selecting. Indicate the dollar amount selected for the Life and Accidental Death & Dismemberment (AD&D), Supplemental Life, Short-Term Disability (STD), and Long-Term Disability (LTD) plans. Benefit offerings are dependent upon employer selection.

Person	Medical	Dental	Vision	Basic Life/AD&D	Supp Life/AD&D	Voluntary AD&D
Employee	☐ ________	☐ ________	☐	☐ $________	☐ $________	☐ $________
Spouse/Domestic Partner	☐	☐	☐	☐ $________	☐ $________	☐ $________
Dependent	☐	☐	☐	☐ $________	☐ $________	☐ $________

Person	STD	LTD	STD Buy Up	LTD Buy Up	Salary $ ________ Required only if Life, STD, or LTD based on salary
Employee	☐	☐	☐	☐	

Life Insurance Beneficiary Full Name and Address (if applying for Life Insurance with UnitedHealthcare)		Relationship
Primary		
Secondary		

D. Other Medical Coverage Information

This section must be completed. (Attach sheet if necessary.)

On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical health plan or policy, including another UnitedHealthcare plan or Medicare? ☐ YES (continue completing this section) ☐ NO (skip the rest of this section)

Name of other carrier ____

Other Group Medical Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date	End Date	Name and date of birth of policyholder for other coverage
Spouse Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				

*B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (married)
S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.
F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

Medicare – Employee Information: If enrolled in Medicare, please attach a copy of your Medicare ID card.

☐ Enrolled in Part A: Effective Date ____________ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)
☐ Enrolled in Part B: Effective Date ____________ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)
☐ Enrolled in Part D: Effective Date ____________ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)
Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work

Medicare – Spouse/Dependent Name: ____

☐ Enrolled in Part A: Effective Date ____________ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)
☐ Enrolled in Part B: Effective Date ____________ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)
☐ Enrolled in Part D: Effective Date ____________ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)
Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work

*Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.

E. Waiver of Coverage

I decline coverage for:
☐ Myself
☐ Spouse
☐ Dependent Children
☐ Myself and all dependents

Declining coverage due to existence of other coverage:
☐ Spouse's Employer's Plan ☐ Individual Plan
☐ Covered by Medicare ☐ Medicaid
☐ COBRA from Prior Employer ☐ VA Eligibility
☐ Tri-Care
☐ I (we) have no other coverage at this time
☐ Other ______________________________

I understand that by waiving coverage at this time, I will not be allowed to participate unless I qualify at a special enrollment period or as a late enrollee, if applicable, or at the next open enrollment period. I acknowledge that I have received the "Important Information" statement which is included with this form.

Employee Initials	Date

F. Signature

Your enrollment in the plan is expressly conditioned upon your acceptance of all terms and conditions contained in this enrollment application. If you do not agree to the following terms and conditions, you may not complete your enrollment.

TERMS AND CONDITIONS

As a condition of my and/or my dependents' participation in the plan, and in consideration for the privileges that come from participation in the plan, I hereby agree for myself and/or for my dependents as follows:

I recognize and understand that the plan contracts with physicians and other providers that make up the plan network. I recognize that all physicians and other providers that participate in the plan network are subject to credentialing under applicable State regulations and pursuant to the plan's network credentialing process. I understand that such credentialing includes a review of provider education, training and licensure. However, by participating in the plan I hereby acknowledge and accept that the plan is not a provider of medical services, and I am aware that obtaining or not obtaining medical care involves significant risks such as serious injury and even death. I acknowledge that the credentialing of physicians and other providers does not in any way reduce this risk. I agree to assume all risks and responsibility for, and hold the plan harmless from, any and all claims for damages, including personal injury or death, medical expenses, disability, lost wages, and loss of earning capacity which may be incurred or associated with medical treatment obtained through a participating physician or other provider. I recognize that all physicians and other providers that participate in the plan network are independent contractors and not the plan's employees or agents and are solely responsible for any malpractice, adverse outcomes, or any other claims arising from medical treatment rendered to me and my dependents. I HEREBY AGREE THAT THE PLAN IS NOT RESPONSIBLE NOR LIABLE FOR ANY ADVICE, COURSE OF TREATMENT, DIAGNOSIS OR ANY OTHER INFORMATION, SERVICES OR PRODUCTS THAT I OR MY DEPENDENTS OBTAIN THROUGH A PARTICIPATING NETWORK PHYSICIAN OR OTHER PROVIDER.

(continued on next page)

F. Signature (Continued)

I recognize and understand that the plan does not recommend, endorse or make any representation about the appropriateness or suitability of any specific tests, products, procedures, treatments, services, or opinions. I recognize that the plan, plan documents, and any health and wellness information provided by the plan, are not intended or implied to be a substitute for professional medical advice, diagnosis or treatment. I agree to confirm any medical information obtained from or through the plan with other sources, and will review all information regarding any medical condition or treatment with my physician. I HEREBY AGREE TO NEVER DISREGARD PROFESSIONAL MEDICAL ADVICE OR DELAY SEEKING MEDICAL TREATMENT BECAUSE OF SOMETHING I HAVE READ OR ACCESSED THROUGH THE PLAN.

I confirm that the information I have provided on this form is complete and accurate.

I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

I acknowledge that I have received the “Important Information” statement which is included at the end of this form.

Date	Employee Signature for all applying and waiving	Spouse Signature (if applying for coverage)

IMPORTANT INFORMATION

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how your plan operates and how it may affect you. In an ever-changing environment, the information can never be complete and we urge you to contact us if, after enrollment, your Certificate of Coverage or other materials do not answer your questions. Further information is available at **www.myuhc.com** or at the toll-free Customer Care number located on the back of your identification card or on other plan materials.

1. We do not provide health care services or make treatment decisions. We help finance and/or administer the health benefit plan in which you are enrolled. That means:
   - We make decisions about whether the health benefit plan you chose will reimburse you for care that you may receive.
   - We do not decide what care you need or will receive. You and your provider make those decisions.
2. We may enter into arrangements where another entity carries out some of our duties, but those entities must operate consistently with our commitment to your plan.
3. We may use individually identifiable information about you to identify for you (and you alone) procedures, products, and services that you may find valuable.
4. We contract with networks of physicians and other providers. Our credentialing process confirms public information about the providers’ licenses and other credentials, but does not assure the quality of the services provided.
5. Physicians and other providers in our networks are independent contractors and are not our employees or agents. We do not control nor do we have a right to control your provider’s treatment or plan.
6. We may enter into agreements with your physician or other provider to share in the cost savings that our approach may generate. We encourage providers in our network to disclose the nature of those arrangements with you. If they do not, we encourage you to talk to your provider about these arrangements.
7. We encourage physicians and other providers to talk with you about care you or your provider think might be valuable.
8. We will use individually identifiable information about you as permitted by law, including in our operations and in our research. We will use anonymous data for commercial purposes including research.

Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for coverage.

I (we) request the indicated group coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from earnings.

I (we) authorize all providers of health services or supplies and any of their representatives to give the following to the HMO/insurance company(ies): any available information about the health history, condition, or treatment of any persons named in this request. I (we) authorize the HMO/insurance company(ies) to use this information to determine eligibility for health coverage and eligibility for benefits under an existing policy.

I (we) also authorize the HMO/insurance company(ies) to give this information to its (their) representatives or to any other organization for the reason notified above. I (we) agree that this authorization is valid for 30 months from the date below. I (we) know that I (we) have the right to ask for and to receive a copy of this authorization.

I understand that the Certificate of Coverage and other documents, notices, and communications regarding my health benefit plan may be transmitted electronically.

I (we) have not given the agent or any other persons any health information not included on the Request for Coverage. I (we) understand that the HMO/insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this Request for Coverage and any attachments.

Guardian Life, P.O. Box 14319,
Lexington, KY 40512

Please print clearly and mark carefully.

Employer Name: **CARROLLTON COMMUNITY UNIT SCHOOL DISTRICT 1**	Group Plan Number: **00503519**	Benefits Effective:________________
PLEASE CHECK APPROPRIATE BOX	Initial Enrollment / Add Employee/Dependents / Drop/Refuse Coverage	Information Change

Class: ALL OTHER ELIGIBLE EMPLOYEES	Division:____________________	Subtotal Code:________________________	**(Please obtain this from your Employer)**

About You: First, MI, Last Name:	**Employer Provided Identification:** ________________________	**Social Security Number** ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Your Social Security Number must be provided if enrolling for Life Coverage. Short Term Disability Coverage and/or Long Term Disability Coverage.	
Address	City	State	Zip
Gender: M F	Date of Birth (mm-dd-yy): ____ - ____ - ____		
Phone (indicate primary):	Home (____) ____ - ____ Work (____) ____ - ____ Mobile (____) ____ - ____		
Email Address (indicate primary)	Home ____________________	Work ____________________	
	Are you married or do you have a partner? Yes No	Date of marriage/union:____-____-_____	
	Do you have children or other dependents? Yes No	Placement date of adopted child: ____-____-_____	

About Your Job:	Job Title:	
Work Status: Active Retired Cobra/State Continuation Hours worked per week: ________	Date of full time hire: _____ - _____ - _____	Annual Salary: $______________

About Your Family: Please include the names of the dependents you wish to enroll for coverage. If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Your dependent's Social Security Number must be provided if enrolling for Life Coverage. Be sure to sign and date (mm-dd-yy) the paper and keep a copy for your records. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.

Name	Add / Drop	Gender	Date of Birth (mm-dd-yyyy)	Status
Spouse (wherever the term "Spouse" appears on this form, it also includes "Partner").		M F	____ - ____ - ____	
Child/Dependent 1:	Add Drop	M F	____ - ____ - ____	Status (check all that apply) Student (post high school) Disabled Non standard dependent
Child/Dependent 2:	Add Drop	M F	____ - ____ - ____	Status (check all that apply) Student (post high school) Disabled Non standard dependent
Child/Dependent 3:	Add Drop	M F	____ - ____ - ____	Status (check all that apply) Student (post high school) Disabled Non standard dependent
Child/Dependent 4:	Add Drop	M F	____ - ____ - ____	Status (check all that apply) Student (post high school) Disabled Non standard dependent

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

DATE FORM PUBLISHED: Jun 10, 2022

Drop Coverage:

Drop Employee Drop Dependents

The date of withdrawal cannot be prior to the date this form is completed and signed.

Last Day of Coverage: ______-______-______

Termination of Employment Retirement

Last Day Worked: ______-______-______

Other Event: ________________

Date of Event: ______-______-______

Coverage Being Dropped:

Dental	Employee	Spouse	Child(ren)
Vision	Employee	Spouse	Child(ren)
Basic Life			
Voluntary Life	Employee	Spouse	Child(ren)

Loss Of Other Coverage:

I and/or my dependents were previously covered under Loss of coverage was due to:

Termination of Employment: ______-______-______

Divorce/Separation ______-______-______

Death of Spouse ______-______-______

Termination/Expiration of Coverage ______-______-______

Coverage Lost Dental Vision

I have been offered the above coverage(s) and wish to drop enrollment for the following reasons:

Covered under another insurance plan

Other ____

(additional information may be required)

Dental Coverage: **You must be enrolled to cover your dependents. Check only one box.**

Your Monthly Premium	Employee Only	Employee and 1 Dependent	EE, Spouse & Dependent/Child(ren)
Option 1: PPO	$22.81	$41.88	$79.38
Option 2: PPO	$51.26	$94.12	$136.73

I do not want Dental Coverage because (Check all that apply):

I am covered under another Dental plan

My spouse is covered under another Dental plan

My dependents are covered under another Dental plan

Vision Coverage: **You must be enrolled to cover your dependents. Check only one box.**

Your Monthly Premium	Employee Only	Employee and 1 Dependent	EE, Spouse & Dependent/Child(ren)
Option 1: Full Feature	$9.51	$13.61	$24.65
Option 2: Full Feature - Designer	$9.51	$13.61	$24.65

I do not want this Vision coverage because (Check all that apply):

I am covered under another Vision plan

My spouse is covered under another Vision plan

My dependents are covered under another Vision plan

Basic Life Coverage with Accidental Death and Dismemberment (AD&D):

Benefit reductions apply. Please see plan administrator.

The amount of life insurance coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions as stated in the certificate of coverage covering you or your dependents.

Policy Amount

Employee Only

☑ $20,000

The Guarantee Issue Amount is $20,000.

* If Employee is 65+ benefit reductions may apply which may change the GI amount. Please see enrollment materials for details.

Name your beneficiaries: (Primary beneficiary percentages must total 100%)

If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Be sure to sign and date (mm-dd-yy) the paper and keep a copy for your records.

Primary Beneficiaries:

Name:__________________ **Social Security Number:**_____-___-______ %___

Date of Birth (mm-dd-yy):___-___-___ **Address/City/State/Zip:**__________________

Phone: ( ) - **Relationship to Employee:**______________________

Name:_________________ **Social Security Number:**_____-___-______ %___

Date of Birth (mm-dd-yy):___-___-___ **Address/City/State/Zip:**__________________

Phone: ( ) - **Relationship to Employee:**______________________

Contingent Beneficiary:_________ **Social Security Number:** ______-___-______

Date of Birth (mm-dd-yy):___-___-___ **Address/City/State/Zip:**__________________

Phone: ( ) - **Relationship to Employee:**______________________

(In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer maintains beneficiary information.)

Please contact your employer for any record of or changes to your beneficiary information.

Spouse and dependent child(ren) – If the intended beneficiary is to be someone other than the employee, please complete the Beneficiary Designation form.

Attention: If any of the beneficiaries named above is a minor (a person under the age of 18 or 21, depending on their state of residency), state law may limit Guardian's ability to pay life insurance proceeds directly to them for as long as they remain a minor. State Uniform Transfers to Minors Act (UTMA) laws, where applicable, may allow for the normal course of payment of these proceeds, or a portion thereof, to the minor beneficiary's designated Custodian to manage on the minor's behalf until they reach adult age. At that time, the proceeds are turned over to the adult child, who can use the proceeds in any way he or she chooses.

Are any of the beneficiaries identified above considered a minor in the state in which they reside? Check one box only. Yes No

If you answered "Yes", please name the legally designated UTMA Custodian for all minor beneficiaries you have designated:

Custodian to Minor Beneficiaries:

Name: ___________________________________ **Social Security Number (or FEIN/TIN # if a corporate entity):**____ ____ ____ ____ _____-____ _____ ____

Date of Birth (mm-dd-yyyy) (if an individual): _____ - _____ - _____

Address/City/State/Zip: ____

Phone: ( ) -

If this Basic Life policy will replace your existing life insurance policy under your current employer, provide the amount of the previous policy $_____________

Important Notes:

- Based on your plan benefits and age, you may be required to complete an evidence of insurability form.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

LIFE INSURANCE *continued*

Voluntary Term Life Coverage With Accidental Death and Dismemberment (AD&D): **You must be enrolled to cover your dependents.** ***Benefit reductions apply. Please see plan administrator.***

The amount of life insurance coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions as stated in the certificate of coverage covering you or your dependents.

Employee

Policy Amount ***Check one box only***

$10,000 $25,000 $50,000 $75,000 $100,000 **$150,000***

Guarantee Issue up to: Employee Less than age 65 $150,000*, 65-69 $50,000, 70+ $10,000. The Health History section must be completed if any amount above the Guarantee Issue Amount is elected.

I do not want this coverage

Add **Voluntary Life for Spouse**

Policy Amount

$5,000 $10,000 $15,000 $20,000 $25,000 $30,000
$35,000 $40,000 $45,000 **$50,000*** $55,000 $60,000
$65,000 $70,000 $75,000

Guarantee Issue up to: Spouse Less than age 65 $50,000*, 65-69 $10,000, $0.

***The amount may not be more than 50% of the employee amount for Voluntary Life.**

I do not want this coverage

Add **Voluntary Life for Dependent/Child(ren)**

Policy Amount

$5,000 **$10,000***

**Guarantee Issue Amount*

***The amount may not be more than 10% of the employee amount for Voluntary Life.**

I do not want this coverage

Important Notes:

- **Based on your plan benefits and age, you may be required to complete an evidence of insurability form.**

LIFE INSURANCE *continued*

Name your beneficiaries: (Primary beneficiary percentages must total 100%) If electing different beneficiaries that are not the same as those named for Basic Life, please name below.

If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Be sure to sign and date (mm-dd-yyyy) the paper and keep a copy for your records.

Primary Beneficiaries:

Name:_______________ **Social Security Number:**___ ___ ___-___ ___-___ ___ ___ ___ %________

Date of Birth (mm-dd-yy):____-____-____ **Address/City/State/Zip:**_______________

Phone: ( ) - **Relationship to Employee:**_______________

Name:_______________ **Social Security Number:**___ ___ ___-___ ___-___ ___ ___ ___ %________

Date of Birth (mm-dd-yy):____-____-____ **Address/City/State/Zip:**_______________

Phone: ( ) - **Relationship to Employee:**_______________

Contingent Beneficiary:_______________ **Social Security Number:** ___ ___ ___-___ ___-___ ___ ___ ___

Date of Birth (mm-dd-yy):____-____-____ **Address/City/State/Zip:**_______________

Phone: ( ) - **Relationship to Employee:**_______________

(In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer maintains beneficiary information.)

Spouse and dependent/child(ren) – If the intended beneficiary is to be someone other than the employee, please complete the Beneficiary Designation form.

Please contact your employer for any record of or changes to your beneficiary information.

Attention: If any of the beneficiaries named above is a minor (a person under the age of 18 or 21, depending on their state of residency), state law may limit Guardian's ability to pay life insurance proceeds directly to them for as long as they remain a minor. State Uniform Transfers to Minors Act (UTMA) laws, where applicable, may allow for the normal course of payment of these proceeds, or a portion thereof, to the minor beneficiary's designated Custodian to manage on the minor's behalf until they reach adult age. At that time, the proceeds are turned over to the adult child, who can use the proceeds in any way he or she chooses.

Are any of the beneficiaries identified above considered a minor in the state in which they reside? Check one box only. Yes No

If you answered "Yes", please name the legally designated UTMA Custodian for all minor beneficiaries you have designated:

Custodian to Minor Beneficiaries:

Name: _______________ **Social Security Number (or FEIN/TIN # if a corporate entity):** ____ ____ ____ ____ ____-____ ____ ____

Date of Birth (mm-dd-yyyy) (if an individual): _____ - _____ - _____ Address/City/State/Zip: _______________

Phone: ( ) -

Signature

I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.

An employee's decision to elect Vision or not elect Vision must be retained until the next plan's Open Enrollment period. If the employee elects not to enroll in vision coverage, they are not eligible to enroll until the plan's next Open Enrollment period.

LIFE ONLY: I understand that life insurance coverage for a dependent, other than a newborn child, will not take effect if that dependent is confined to a hospital or other health care facility, or is home confined, or is unable to perform the normal activities of someone of like age and sex.

Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet.

I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined in the benefit booklet.) This does not apply to eligible retirees.

I understand that if I waive coverage, I may not be eligible to enroll until the next open enrollment period. Late entrant penalties may apply. I understand that I may also have to provide, at my own expense, proof of each person's insurability. Guardian or its designee has the right to reject my request.

I understand that my coverage will not be effective until approved by Guardian or its designated underwriter.

I hereby apply for the group benefit(s) that I have chosen above.

I understand that I must meet eligibility requirements for all coverages that I have chosen above.

I agree that my employer may deduct premiums from my pay if they are required for the coverage I have chosen above.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

I acknowledge and consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.

I consent to electronic communication from Guardian, such as emails and text messages, regarding my coverage(s). I may change this election only by providing (thirty) 30 days prior written notice.

I attest that the information provided above is true and correct to the best of my knowledge.

Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information or conceals for purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

The state in which you reside may have a specific state fraud warning. Please refer to the attached Fraud Warning Statements page.

NOTICE: This coverage under the policy may only be issued if you have minimum essential coverage within the meaning of section 500A(f) of the Internal Revenue Code. By signing below, you are confirming that you have other health coverage.

SIGNATURE OF EMPLOYEE X ______________________ **DATE** ______________

Enrollment Kit 00503519, 0001, EN

Fraud Warning Statements

The laws of several states require the following statements to appear on the enrollment form:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Indiana and Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefit.

Maryland : Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Missouri: Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any knowingly false information, or conceals for purpose of misleading information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits subject to the conditions/provisions of the policy.

Oregon: Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially false information, or conceals for purpose of misleading information concerning any fact material thereto, may be committing a fraudulent act, and may be subject to civil penalties or dental of insurance benefits.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Ohio: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with the intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Rhode Island: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Virginia: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.