

New Employee Benefits Packet

Town of Webster
350 Main Street
Webster, MA 01570

Courtney M. Friedland
Health Insurance Coordinator
(508) 949-3800 ext. 1005
ctyrell@webster-ma.gov

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

► **See page 2 for more information on these rights and how to exercise them**

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

► **See page 3 for more information on these choices and how to exercise them**

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

► **See pages 3 and 4 for more information on these uses and disclosures**

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

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

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

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

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

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

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

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

Treat you

- We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

continued on next page

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

Help with public health and safety issues

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

Do research

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

Comply with the law

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

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

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

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

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

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

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

Changes to the Terms of this Notice

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

July 16, 2018

This Notice of Privacy Practices applies to the following organizations.

Courtney M. Friedland
(508) 949-3800 ext. 1005
ctyrell@webster-ma.gov



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 3-31-2017)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

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

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name \\ Town of Webster	4. Employer Identification Number (EIN) 046001342	
5. Employer address 350 Main Street	6. Employer phone number 508-949-3800 extn 1005	
7. City Webster	8. State MA	9. ZIP code 01570
10. Who can we contact about employee health coverage at this job? Courtney Friedland		
11. Phone number (if different from above) 508-949-3800 extn 1005	12. Email address ctyrell@webster-ma.gov	

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

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

All employees. Eligible employees are:

Some employees. Eligible employees are:

Defined Under Massachusetts General Law 32B

- With respect to dependents:

We do offer coverage. Eligible dependents are:

Defined Under Massachusetts General Law 32B

We do not offer coverage.

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

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

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

**Town of Webster
350 Main Street
Webster, MA 01570**

Continuation Coverage Rights Under COBRA

Introduction

You are receiving this notice because you have recently become covered under a group health plan with the Town of Webster. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

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

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

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

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

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

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

You must provide this notice to: Town of Webster

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

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

Second qualifying event extension of 18-month period of continuation coverage

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

Are there other options besides COBRA Continuation Coverage?

Yes, Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period". Some of these options may cost less than COBRA continuation. You can learn more about many of these options at www.HealthCare.gov or 1-800-318-2596.

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

The Plan Administrator is the Town of Webster. Group Benefits Strategies is responsible for administering Cobra continuation Coverage. Group Benefits Strategies is located at 11 Midstate Drive, Suite 110, Auburn, MA 01501. (800) 229-8008.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2015. Contact your State for more information on eligibility -

MASSACHUSETTS – Medicaid and CHIP	MAINE – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY: 1-800-977-6741
NEW HAMPSHIRE – Medicaid	RHODE ISLAND – Medicaid
Website: http://www.dhhs.nh.gov/oi/documents/hippapp.pdf Phone: 1-603-271-5218	Website: http://www.ohhs.ri.gov Phone: 1-401-462-5300
VERMONT – Medicaid	
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	

To see if any other states have added a premium assistance program since January 31, 2015, or for more information on special enrollment rights, contact either:

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

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

Town of Webster
Open Enrollment Rates Effective 7/1/2024

Active Employees and Non- Medicare Eligible Retirees
(7/1/2024 - 6/30/2025)

		Monthly Rate	Monthly Retiree 50%	Monthly Employee 25%	Employee Pay Periods		
					52	26	39
HPI - Harvard Pilgrim EPO	Individual	\$935.71	\$467.85	\$233.93	\$53.98	\$107.97	\$71.98
	Family	\$2,429.36	\$1,214.68	\$607.34	\$140.16	\$280.31	\$186.87
HPI - Harvard Pilgrim PPO	Individual	\$1,234.06	\$617.03	\$308.51	\$71.19	\$142.39	\$94.93
	Family	\$3,071.33	\$1,535.67	\$767.83	\$177.19	\$354.38	\$236.26
HPI - Harvard Pilgrim EPO QHDP	Individual	\$650.10	\$325.05	\$162.53	\$37.51	\$75.01	\$50.01
	Family	\$1,722.60	\$861.30	\$430.65	\$99.38	\$198.76	\$132.51

Altus Dental Plan - Low
(7/1/2024 - 6/30/2025)

		Monthly Rate	Employee Pay Periods		
			52	26	39
Individual	\$40.58	\$9.36	\$18.73	\$12.49	
	\$81.16	\$18.73	\$37.46	\$24.97	
	\$123.52	\$28.50	\$57.01	\$38.01	

Altus Dental Plan - High
(7/1/2024 - 6/30/2025)

		Monthly Rate	Employee Pay Periods		
			52	26	39
Individual	\$51.86	\$11.97	\$23.94	\$15.96	
	\$103.74	\$23.94	\$47.88	\$31.92	
	\$161.94	\$37.37	\$74.74	\$49.83	

Altus Dental Plan - Preventative Plan
(7/1/2024 - 6/30/2025)

		Monthly Rate	Employee Pay Periods		
			52	26	39
Individual	\$20.00	\$4.62	\$9.23	\$6.15	
	\$40.00	\$9.23	\$18.46	\$12.31	
	\$70.00	\$16.15	\$32.31	\$21.54	

		Monthly Rate	Employee Pay Periods		
			52	26	39
Altus Vision (7/1/2024- 6/30/2025)	Employee	\$5.05	\$1.17	\$2.33	\$1.55
	Emp. plus spouse	\$10.10	\$2.33	\$4.66	\$3.11
	Employee plus one or more children	\$12.96	\$2.99	\$5.98	\$3.99
	Family	\$19.81	\$4.57	\$9.14	\$6.10

USable Life Insurance
(7/1/2024 - 6/30/2025)

Group Life and AD&D
\$5000/\$5000 \$ 3.40/month

Senior Plans

		Monthly Rate	Retiree 50%
Aetna Medicare Advantage PPO			
Requires Medicare A & B (1/2024 - 12/31/2024)		\$289.72	\$144.86
Altus Dental Retiree Plan (7/1/2023 - 6/30/2024)	Individual	\$47.24	USable Life Insurance (7/1/2023 - 6/30/2024)
	2-Person	\$94.48	\$ 1,000
	Family	\$165.34	\$ 0.75/month

Member Enrollment / Change Form

Employer Name: Town of Webster

Group Number: BP3

To Be Completed by Employer (this section must be completed prior to submitting to Health Plans)

Hire Date: _____ Effective Date: _____ Termination Date: _____ Change Effective Date: _____

Please indicate: Active COBRA Department/Division/Location (if applicable): _____Please indicate New Employee Open Enrollment Change of Address Special EnrollmentPlease indicate Add Dependent Coverage - Reason: _____ if requesting coverage for employee's spouse: _____Please indicate Terminate Dependent Coverage - Reason: _____ date of marriage _____Please indicate Change of Status - Reason: _____ Other: _____

To Be Completed by Employee

Employee Last Name	First Name	MI	Social Security Number	Date of Birth	
Mailing Address		City	ST	ZIP Code	
Gender	Marital Status	Email Address			Primary Phone

Health Coverage Election

Medical Plan Option (select one): Network (EPO)- QHDP PPO Plan Network Tiering

Employee Only	or	Employee + : Spouse/Partner	Family	Ex-Spouse
<input type="checkbox"/> Medical		<input type="checkbox"/> Medical	<input type="checkbox"/> Medical	<input type="checkbox"/> Medical

Dependents

Last Name	First Name	MI	Gender	Date of Birth	Relationship	Dependent Social Security Number (REQUIRED)	Add Dependent	Drop Dependent
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>

Are you or any of your dependents covered by another **medical** plan? Yes No Self Spouse/Partner Child(ren) Ex-Spouse

If yes, Medical Policy No. & Insurance Co.: _____ Policyholder: _____

Name/Address of Policyholder's Employer: _____

Election of Coverage

Important

To accept coverage, select YES, sign, and date this section.

YES • I wish to elect coverage under my employer's benefit plan for the coverage indicated above. I understand that my application will be subject to the terms of the Plan. I authorize any required deductions from my earnings. I authorize the release of medical records to Health Plans, Inc. or its representatives. A photocopy shall be as valid as the original. • I certify that the above information is accurate and complete and I am actively working the minimum number of hours required for coverage.

Signature: _____

Signature of Employee

Date Signed

Waiver of Coverage

NO • If you are declining enrollment in the Plan for yourself and/or your dependents (including your spouse) because you and/or your dependents are covered under other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Signature: _____

Signature of Employee

Date Signed

*** PLEASE RETURN COMPLETED FORM TO YOUR HUMAN RESOURCES DEPARTMENT ***

Health Plans, Inc. – Corporate Headquarters • PO Box 5199 • Westborough, MA 01581 • 800-532-7575

Enroll_Med_All_04on8

Town of Webster – Network Plan

Medical Benefits for Group BP3 Effective 7/1/2024

Covered Services	Tier 1	Tier 2	Tier 3
Deductible & Out-of-Pocket			
Plan Year Deductible <i>Single Family</i>	None None	\$250 \$750	\$250 \$750
Annual Out-of-Pocket Maximum (<i>includes Deductible, Coinsurance and Copayments</i>) <i>Single Family</i>	\$2,500 \$5,000	\$2,500 \$5,000	\$2,500 \$5,000
Preventive Care			
Routine Physicals, Gynecological Exams & Family Planning	No Charge	No Charge	No Charge
Routine Hearing Exams & Routine Vision Exams (<i>one Vision Exam every 24 months</i>)	No Charge	No Charge	No Charge
Other Services			
Office Visit – Primary Care and Urgent Care	\$20 copay	\$20 copay	\$20 copay
Office Visit – Specialist Care	\$35 copay	\$35 copay	\$35 copay
Chiropractic Visit, Speech Therapy, Occupational & Physical Therapy (<i>up to 60 visits per Plan year for Occupational and Physical Therapy</i>)	\$25 copay	\$25 copay	\$25 copay
Diagnostic Lab & X-Ray	No Charge	Deductible then no charge	Deductible then no charge
CT, MRI, PET Scan & Nuclear Cardiac Imaging Tests (<i>done in general hospitals per category, per service date</i>)	\$100 copay	Deductible then \$100 copay	Deductible then \$100 copay
CT, MRI, PET Scan & Nuclear Cardiac Imaging Tests (<i>done by other covered providers</i>)	\$100 copay	\$100 copay	\$100 copay
Ambulatory Surgical Facility per Admission	\$150 copay	\$150 copay	\$150 copay
Inpatient Hospital & Surgical Day Care Unit per Admission	\$300 copay	Deductible then \$300 copay	Deductible then \$700 copay
Mental Health Hospital or Substance Abuse Facility	\$150 copay	\$150 copay	\$150 copay
Mental Health or Substance Abuse Treatment	\$15 copay	\$15 copay	\$15 copay
Home Health Care and Hospice	No Charge	No Charge	No Charge
Emergency Room (<i>copay waived if admitted</i>)	\$100 copay	\$100 copay	\$100 copay
Nurse Practitioner (<i>not billed by PCP</i>)	\$15 copay	\$15 copay	\$15 copay
Fitness Reimbursement & Weight Loss Reimbursement	\$150 per year each per category		
Prescription Drug Benefits			
Retail Pharmacy (<i>up to a 30-day supply</i>)	\$10 (Generic) / \$25 (Preferred Brand) / \$50 (Non-Preferred Brand)		
Mail Order (<i>up to a 90-day supply</i>)	\$20 (Generic) / \$50 (Preferred Brand) / \$110 (Non-Preferred Brand)		

NOTE: This Summary provides you with an overview of your Plan benefits and is not a complete statement of all Plan provisions, limitations and exclusions. Please refer to your Summary Plan Description and amendments for complete details. In the event of any inconsistency between this Summary and your Plan Document, the Plan Document and any applicable amendments will govern. Please refer to your Plan Document and Amendments for complete details as well as the services that require prior authorization.

Town of Webster — PPO Plan

Medical Benefits for Group BP3 Effective 7/1/2024

Covered Services	In-Network Providers	Out-of-Network Providers
Deductible & Out-of-Pocket		
Plan Year Deductible		
Single Family	\$250 \$750	\$400 \$800
Plan Year Out-of-Pocket Maximum (includes Deductible coinsurance and copays)		
Single Family	\$2,000 \$4,000	\$3,000 per member
Preventive Care		
Routine Physicals, Gynecological Exams & Family Planning	No Charge	No Charge
Routine Hearing Exams & Routine Vision Exams (one Vision Exam every 24 months)	No Charge	No Charge
Other Services		
Office Visit – Primary Care and Urgent Care	\$20 copay	Deductible then 20%
Office Visit – Specialist Care	\$35 copay	Deductible then 20%
Chiropractic Visit, Speech Therapy, Occupational & Physical Therapy <i>(up to 60 visits per Plan year for Occupational and Physical Therapy and up to 20 visits per plan year for Chiropractic)</i>	\$20 copay	Deductible then 20%
Diagnostic Lab & X-Ray	Deductible then no charge	Deductible then 20%
CT, MRI, PET Scan & Nuclear Cardiac Imaging Tests <i>(done in general hospitals per category, per service date)</i>	Deductible then \$100 copay	Deductible then 20%
CT, MRI, PET Scan & Nuclear Cardiac Imaging Tests <i>(done by other covered providers)</i>	Deductible then \$150 copay	Deductible then 20%
Ambulatory Surgical Facility per Admission	Deductible then \$150 copay	Deductible then 20%
Inpatient Hospital & Surgical Day Care Unit per Admission	Deductible then \$300 copay Deductible then \$700 copay for certain hospitals	Deductible then 20%
Mental Health Hospital or Substance Abuse Facility	Deductible then \$200 copay	Deductible then 20%
Mental Health or Substance Abuse Treatment	Deductible then \$15 copay	Deductible then 20%
Home Health Care and Hospice	Deductible then no charge	Deductible then 20%
Emergency Room <i>(copay waived if admitted)</i>	\$100 copay	\$100 copay
Nurse Practitioner <i>(not billed by PCP)</i>	\$20 copay	Deductible then 20%
Fitness Reimbursement & Weight Loss Reimbursement	\$150 per year each per category	
Prescription Drug Benefits		
Retail Pharmacy (up to a 30-day supply)	\$10 (Generic) / \$25 (Preferred Brand) / \$50 (Non-Preferred Brand)	
Mail Order (up to a 90-day supply)	\$20 (Generic) / \$50 (Preferred Brand) / \$110 (Non-Preferred Brand)	

NOTE: This Summary provides you with an overview of your Plan benefits and is not a complete statement of all Plan provisions, limitations and exclusions. Please refer to your Summary Plan Description and amendments for complete details. In the event of any inconsistency between this Summary and your Plan Document, the Plan Document and any applicable amendments will govern. Please refer to your Plan Document and Amendments for complete details as well as the services that require prior authorization.

Town of Webster — Network (EPO) Plan QHDP

Medical Benefits for Group BP3 Effective 7/1/2024

Covered Services	In-Network Providers
Deductible & Out-of-Pocket	
Plan Year Deductible	<i>Single Family</i> \$2,000 \$4,000
Plan Year Out-of-Pocket Maximum (includes Deductible, coinsurance and copays)	<i>Single Family</i> \$4,000 \$8,000 <i>Individual within the Family</i> \$4,000
Preventive Care	
Routine Physicals & Gynecological Exams	100% (deductible waived)
Other Services	
Office Visit – Primary Care	Deductible then 100%
Office Visit – Specialist Care	Deductible then 100%
Chiropractic Visit <i>20 visits per plan year</i>	Deductible then 100%
Diagnostic Lab & X-Ray	Deductible then 100%
CT, MRI & PET Scan	Deductible then 100%
Outpatient Surgery	Deductible then 100%
Inpatient Hospital	Deductible then 100%
Behavioral Health Hospital Service	Deductible then 100%
Behavioral Health Office Visit	Deductible then 100%
Occupational and Physical Therapy <i>20 visits combined per plan year</i>	Deductible then 100%
Speech Therapy	Deductible then 100%
Ambulance (emergency)	Deductible then 100%
Emergency Room	Deductible then 100%
Urgent Care	Deductible then 100%
Fitness Reimbursement	\$150 per plan year
Prescription Drug Benefits	
Retail Pharmacy (up to a 30-day supply)	Deductible then \$10 (Generic) / Deductible then \$25 (Preferred Brand) / Deductible then \$40 (Non-Preferred Brand)
Mail Order (up to a 90-day supply)	Deductible then \$20 (Generic) / Deductible then \$50 (Preferred Brand) / Deductible then \$120 (Non-Preferred Brand)
Express Scripts	

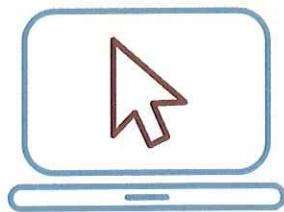
NOTE: This Summary provides you with an overview of your Plan benefits and is not a complete statement of all Plan provisions, limitations and exclusions. Please refer to your Summary Plan Description and amendments for complete details. In the event of any inconsistency between this Summary and your Plan Document, the Plan Document and any applicable amendments will govern. Please refer to your Plan Document and Amendments for complete details as well as the services that require prior authorization.

Manage your plan online With My Plan

24/7 access to your plan and account details

Register in Minutes!

- 1 Go to the website listed on the back of your member ID card (it will be at the top)
- 2 Visit the **Members** section and click the link to **Get Registered**
- 3 Enter your information to create your username and password



If you are a dependent, be sure to have the five-digit home ZIP Code and the last four digits of the employee's (plan subscriber's) social security number.

Access all of your account details* in one secure location anytime, anywhere!

- Review your claims
- Check your benefits
- Access your prescription drug plan
- Search your provider network
- Download a report of your claims
- Request claim reimbursements
- View, print or order your member ID card
- View or print applicable tax forms
- Find a Primary Care Provider (PCP)
- View your health spending account details



** You will have access to details applicable to your plan. Please note, not all of the items listed above apply for all plans.*

On your mobile device!



Have questions? Contact HPI Customer Service at the phone number or website listed on the back of your member ID card.



AchieveHealth®

Programs For Your Health

Personalized programs included in your benefit plan.

Your Health. Your Benefits.

When it comes to feeling your best, your needs are unique to you. Sometimes a little encouragement, understanding and support is all you need to feel better. Whether you're actively trying to improve your well-being, or you're just thinking about it, you and your family have access to unlimited, confidential health coaching sessions to help you reach your goals.

What is my health coaching benefit?

- Unlimited coaching sessions available to you and your covered family members
- Offered at no cost to you
- Completely confidential

Health coaches can help you to:

- Make a personalized plan to help you achieve success
- Access tools to help you reach your goals
- Incorporate lifestyle changes that will help you maintain your goals for a lifetime such as:
 - Losing weight and keeping it off
 - Quitting tobacco use—for good
 - Reducing stress in all areas of your life
 - Feeling more physically fit
 - Gaining more control over your chronic condition (diabetes, high blood pressure, high cholesterol or asthma just to name a few)

Or, just talk to someone about your health who can help motivate you.

How it works

- Talk with your coach over the phone at times convenient for you.
- Appointments can be up to one hour, depending on your needs.
- Coaches are available M–Th 8am to 10pm and Friday, 8am to 6pm (EST).

Additional health programs

- Case management - support when you need it.
- Personalized preventive health report.



To learn more, or to enroll in the program:

Call (866) 234-4635 to speak to a health coach

Or, enroll online at enroll.trestletree.com

hpi
TM

3

REASONS TO JOIN

The Diabetes Care Rewards Program

The Good Health Gateway® Diabetes Care Rewards Program, offered by the Massachusetts Strategic Health Group to their health plan members, **rewards you with \$0 copays on all covered diabetes medications and supplies** for managing your diabetes.

**Join at GoodHealthGateway.com
or by calling 800.643.8028**

1. YOUR DOCTORS

Complete routine diabetes labs and exams with your doctors, designed to keep your diabetes in check so you feel well and live healthy.



2. YOUR CARE PLAN

Create a personalized Diabetes Health Action Plan® care guide with the Good Health Gateway clinical team, designed to help you set goals to effectively manage your diabetes.



3. YOUR REWARDS

Earn \$0 copays on all your covered diabetes medications and supplies by completing your labs and exams and developing your action plan.



Join Today

800.643.8028

GoodHealthGateway.com

 **Good Health
GATEWAY®**
Diabetes Care Rewards Program

MSHG

Massachusetts
Strategic
Health Group

The Good Health Gateway Diabetes Care Rewards Program is a private and confidential service provided by the MSHG for their health plan members. See backside for participating employers and eligible health plans.



Massachusetts
Strategic
Health Group

For health plan members



Why participate in the Diabetes Care Rewards Program

We'll help you improve your health and reduce your risk of heart disease and stroke. And you'll get a **Good Health Gateway® RX Rewards Card** to get your \$0 copays.

How to get your Good Health Gateway RX Rewards Card for \$0 copays



Register at GoodHealthGateway.com

Or call our **Good Health Gateway** HelpLine at 800.643.8028 Monday through Thursday 8:30 am - 6:00 pm and Friday 8:30 am - 5:00 pm EST.



Call the **Good Health Gateway** HelpLine at 800.643.8028 to:

- Review the program requirements.
- Schedule a telephone appointment with our Diabetes Educator.



Complete the call with our Diabetes Educator to develop your personal **Diabetes Health Action Plan®** Care Guide.

And confirm you will share your action plan with the doctor that helps you manage your diabetes.



Submit a Provider Confirmation Form to verify completion of the required medical exams and lab tests listed below.

Any of the exams/labs completed in the past year will count toward the requirement.

- Annual foot exam
- Annual eye exam
- Annual laboratory work-up of your fasting blood lipid levels
- Annual laboratory work-up of your urine/protein levels
- Laboratory work-up of your Hemoglobin A1c levels every 6 months



Get \$0 copays on covered diabetes medications and supplies using your **Good Health Gateway Rx Rewards Card** at your local, in-network pharmacy or through OPTUMRx® Home Delivery when the program requirements are met.

MSHG is committed to helping you achieve your best health status. Rewards for participating in this program are available to all eligible members who meet the program requirements. If your doctor determines you do not need one of the activities required in this program, they can simply indicate not needed beside that requirement, and you will receive credit for this requirement.

Participation in the program is voluntary and confidential. HIPAA privacy and security standards are used to ensure the protection of your healthcare information.



800.643.8028

GOODHEALTHGATEWAY.COM



Managing diabetes can be complicated.

The Massachusetts Strategic Health Group (MSHG) is pleased to offer the **Good Health Gateway® Diabetes Care Rewards Program**. The program is offered to MSHG health plan members living with diabetes or pre-diabetes who are on an active health plan.

When you join the program, you receive expert support and guidance to help you manage your diabetes while earning \$0 copays on most diabetes medications and supplies for meeting program requirements.

How to get started



Join the Diabetes Care Rewards Program at GoodHealthGateway.com



Have a telehealth call with the Diabetes Educator to develop your personal **Diabetes Health Action Plan® Care Guide**.



See your doctors and complete important diabetes labs and exams to support your health.



Get **\$0 copays on most diabetes medications and supplies**.



**Join the program at
GoodHealthGateway.com
or by calling the HelpLine at
800.643.8028.
Hablamos Espanol.**

Participation in the program is voluntary and confidential. HIPAA privacy and security standards are used to ensure the protection of your healthcare information.

Member Employers of MSHG

Town of Douglas

Town of Webster

Dudley Charlton Regional School District





\$50 GIFT CARD OFFER!*

**SIMPLE.
SAFE.
SMART.**

SIGN UP TODAY

*Receive a \$50 Amazon Gift Card for enrolling in the CANARX program with a qualifying prescription for a 90 day supply with 3 refills!

Medications FREE to your door!

See reverse for a full list of medications.

CANARX is a voluntary international mail order prescription program that is available to eligible employees and their dependents enrolled in a **HDHP** or **HSA** health plan covered by Massachusetts Strategic Health Group.

Brand name medications, in the original factory-sealed manufacturers packaging, are delivered **DIRECT TO YOUR DOOR** from certified pharmacies in Canada, the United Kingdom and Australia. **YOU PAY NOTHING** thanks to the savings CANARX brings to your plan.

Getting started is super easy!

1. Check to see if a medication is offered - call CANARX at **1-866-893-6337** or to view the complete formulary - and enroll online or download an enrollment form - visit www.canarx.com (WebID: **MSHG**).
2. Ask your doctor for a prescription for a 3-month supply, with 3 refills.
3. Submit documentation (completed enrollment form, prescription and a copy of your photo ID).
4. Sit back and relax...medication will be mailed direct to your home within 4 weeks!

- \$0 Copay**
- 350+ FREE Brand Name Medications**
- Easy, convenient refills**
- Refills only, no "new to you" meds**
- No additional costs**

For More Information



1-866-893-6337
www.canarx.com
WebID: **MSHG**

ACIPHEX 20MG	CADUET 5/10MG	FLOVENT 44MCG	MIRAPEX ER 0.375MG	STALEVO (G) 125MG
ACTONEL (G) 35MG	CADUET 5/20MG	FLOVENT 110MCG	MIRAPEX ER 0.75MG	STEGLUJAN 5MG-100MG
ACTONEL (G) 150MG	CADUET 5/40MG	FLOVENT 220MCG	MIRAPEX ER 1.5MG	STEGLUJAN 15MG-100MG
ACTOPLUS (G) 15MG-850MG	CADUET 5/80MG	FLOVENT DISKUS 100MCG	MIRAPEX ER 2.25MG	STIOLTO RESPIMAT 2.5/2.5MCG
ACULAR (G) 0.5%	CADUET 10/10MG	FLOVENT DISKUS 250MCG	MIRAPEX ER 3MG	STRIVERDI RESPIMAT 2.5MCG
ACULAR LS (G) 0.4%	CADUET 10/20MG	FOSAMAX PLUS D 70MG-2800IU	MIRAPEX ER 3.75MG	SUTENT 12.5MG
ADVAIR DISKUS 100MCG	CADUET 10/40MG	FOSAMAX PLUS D 70MG-5600IU	MIRAPEX ER 4.5MG	SUTENT 25MG
ADVAIR DISKUS 250MCG	CADUET 10/80MG	FOSRENOL CHEW 500MG	MIRVASO 0.33%	SUTENT 37.5MG
ADVAIR DISKUS 500MCG	CARDURA XL 4MG	FOSRENOL CHEW 750MG	MOTEGRITY 1MG	SUTENT 50MG
ADVAIR HFA 4/21MCG	CARDURA XL 8MG	FOSRENOL CHEW 1000MG	MOTEGRITY 2MG	SYMBICORT 160MCG-4.5MCG
ADVAIR HFA 115/21MCG	CEQUA (G) 0.09%	FOSRENOL POWDER 750MG	MULTAQ 400MG	SYMTUZA
ADVAIR HFA 230/21MCG	COLAZAL 750MG	FOSRENOL POWDER 1000MG	NATAZIA 3/2-2/2-3/1MG	SYNJARDY 5MG/500MG
ALOCRIL 2%	COMBIGAN 0.2-0.5%	GENVOYA	NESINA 6.25MG	SYNJARDY 5MG/1000MG
ALOMIDE 0.1%	COMBIVENT RESPIMAT	GILENYA (G) 0.5MG	NESINA 12.5MG	SYNJARDY 12.5MG/500MG
ALPHAGAN-P 0.15%	20MCG/100MCG	GLUMETZA ER 1000MG	NESINA 25MG	SYNJARDY 12.5MG/1000MG
ALREX 0.2%	CORGARD 80MG	GLYXAMBI 10MG/5MG	NEUPRO 1MG	TASMAR 100MG
ALVESCO 80MCG	COSOPT PF 2%/0.5%	GLYXAMBI 25MG/5MG	NEUPRO 2MG	TECFIDERA (G) 120MG
ALVESCO 160MCG	CRESTOR (G) 5MG	IBRANCE 75MG	NEUPRO 3MG	TECFIDERA (G) 240MG
ANAPROX DS 550MG	CRESTOR (G) 10MG	IBRANCE 100MG	NEUPRO 4MG	TEKTURNA 150MG
ANORO ELLIPTA 62.5/25MCG	CRESTOR (G) 20MG	IBRANCE 125MG	NEUPRO 6MG	TEKTURNA 300MG
APTIOM 200MG	CRESTOR (G) 40MG	ILEVRO 0.3%	NEUPRO 8MG	TIVICAY 50MG
APTIOM 400MG	CYMBALTA (G) 20MG	IMURAN (G) 50MG	NEVANAC 3MG/ML	TOBI PODHALER 28MG
APTIOM 600MG	CYMBALTA (G) 30MG	INCRUSE ELLIPTA 62.5MCG	NEXAVAR 200MG	TOBREX OINT 0.3%
APTIOM 800MG	CYMBALTA (G) 60MG	INSPRA (G) 25MG	NIEXUM (G) 40MG	TRADJENTA 5MG
ARAVA 10MG	CYTOTEC (G) 200MCG	INSPRA (G) 50MG	NEXLETOL 180MG	TRELEGY ELLIPTA
ARAVA 20MG	DALIRESP 250MCG	INVEGA 3MG	NEXLIZET 180MG-10MG	100-62.5-25MCG
ARNUITY ELLIPTA 100MCG	DALIRESP 500MCG	INVOKAMET 50MG-500MG	NUBEQA 300MG	TRELEGY ELLIPTA
ARNUITY ELLIPTA 200MCG	DEXILANT DR 30MG	INVOKAMET 50MG-1000MG	NURTEC ODT 75MG	200-62.5-25MCG
AROMASIN (G) 25MG	DEXILANT DR 60MG	INVOKAMET 150MG-500MG	ODEFSEY	TRIBENZOR 20/5/12.5MG
ASMANEX TWISTHALER 110MCG	DIOVAN (G) 40MG	INVOKAMET 150MG-1000MG	200MG-25MG-25MG	TRIBENZOR 40/5/12.5MG
ASMANEX TWISTHALER 220MCG	DIOVAN (G) 80MG	INVOKANA 100MG	OLUMIANT 2MG	TRIBENZOR 40/5/25MG
ASTAGRAF XL 0.5MG	DIOVAN (G) 160MG	INVOKANA 300MG	OSPHENA 60MG	TRIBENZOR 40/10/12.5MG
ASTAGRAF XL 1MG	DIOVAN (G) 320MG	IRESSA 250MG	OTEZLA 30MG	TRIBENZOR 40/10/25MG
ASTAGRAF XL 5MG	DIOVAN HCT (G) 80/12.5MG	ISENTRESS 400MG	PLAQUENIL 200MG	TRINTELLIX 5MG
ATACAND 4MG	DIOVAN HCT (G) 160/12.5MG	JAKAFI 5MG	PRADAXA 150MG	TRINTELLIX 10MG
ATACAND 8MG	DIOVAN HCT (G) 160/25MG	JAKAFI 10MG	PRESTALIA 3.5MG/2.5MG	TRINTELLIX 20MG
ATACAND 16MG	DIVIGEL 0.25MG	JAKAFI 15MG	PRESTALIA 7MG/5MG	TRIUMEQ 600-50-300MG
ATACAND 32MG	DIVIGEL 0.5MG	JAKAFI 20MG	PRESTALIA 14MG/10MG	TUDORZA PRESSAIR 400MCG
ATACAND HCT 32MG/25MG	DIVIGEL 1MG	JALYN 0.5MG/0.4MG	PREVACID SOLUTAB 15MG	ULORIC 80MG
ATACAND HCT 16MG/12.5MG	DOVATO 50MG-300MG	JANUMET 50/500MG	PREVACID SOLUTAB 30MG	UROCIT-K (G) 10MEQ
ATACAND HCT 32MG/12.5MG	DULERA 100MCG/5MCG	JANUMET 50/1000MG	PREZISTA 600MG	URSO 250MG
ATELVIK DR 35MG	DULERA 200MCG/5MCG	JANUMET XR 50MG/500MG	PREZISTA 800MG	VELPHORO 500MG
ATROVENT HFA 20UG	DUOBRII 0.01%-0.045%	JANUMET XR 50MG/1000MG	PRISTIQ 50MG	VENTOLIN HFA 90MCG
AUBAGIO (G) 14MG	EDARBI 40MG	JANUVIA 25MG	PRISTIQ 100MG	VIIBRYD 10MG
AVALIDE (G) 150MG/12.5MG	EDARBI 80MG	JANUVIA 50MG	PROZAC (G) 20MG	VIIBRYD 20MG
AVALIDE (G) 300MG/12.5MG	EDARBYCLOR 40MG/12.5MG	JANUVIA 100MG	QTERN 10-5MG	VIIBRYD 40MG
AVAPRO (G) 75MG	EDARBYCLOR 40MG/25MG	JARDIANCE 10MG	QVAR REDIHALER 40MCG	VRAYLAR 1.5MG
AVAPRO (G) 300MG	EDECIRIN 25MG	JARDIANCE 25MG	QVAR REDIHALER 80MCG	VRAYLAR 3MG
AVODART (G) 0.5MG	EDURANT 25MG	JENTADUETO 2.5MG-500MG	RANEXA (G) 500MG	VRAYLAR 4.5MG
AZOPT 1%	EFFEXOR XR (G) 37.5MG	JENTADUETO 2.5MG-850MG	RAPAMUNE 0.5MG	VRAYLAR 6MG
AZOR 20/5MG	EFFEXOR XR (G) 75MG	JENTADUETO 2.5MG-1000MG	RAPAMUNE 2MG	VUMERITY 231MG
AZOR 40/5MG	EFFEXOR XR (G) 150MG	JUBLIA 10%	RENAGEL 800MG	VYTORIN 10/10MG
AZOR 40/10MG	ELIQUIS 2.5MG	JULUCA 50MG-25MG	RESTASIS MULTIDOSE (G) 0.05%	VYTORIN 10/20MG
BECONASE AQ 42MCG	ELIQUIS 5MG	KAZANO 12.5/500MG	RESTASIS VIALS 0.05%	VYTORIN 10/40MG
BENICAR (G) 20MG	ENTRESTO 24MG-26MG	KAZANO 12.5/1000MG	REXULTI 0.25MG	VYTORIN 10/80MG
BENICAR (G) 40MG	ENTRESTO 49MG-51MG	KEPPRA (G) 1000MG	REXULTI 0.5MG	WAKIX 4.5MG
BENICAR HCT (G) 20MG/12.5MG	ENTRESTO 97MG-103MG	KERENDIA 10MG	REXULTI 1MG	WAKIX 17.8MG
BENICAR HCT (G) 40MG/12.5MG	PIPIVIR / HBV (G) 100MG	KISQALI 200MG	REXULTI 2MG	WELCHOL (G) 625MG
BEPREVE 1.5%	EUCRISA 2%	LATUDA 20MG	REXULTI 3MG	WELLBUTRIN XL (G) 150MG
BETIMOL 0.25%	EVISTA (G) 60MG	LATUDA 40MG	REXULTI 4MG	WELLBUTRIN XL (G) 300MG
BETIMOL 0.5%	EVOTAZ 300MG-150MG	LATUDA 60MG	RINVOQ 15MG	XADAGO 50MG
BETOPTIC S 0.25%	EXELOX (G) 4.6MG/24HR	LATUDA 80MG	RINVOQ 30MG	XADAGO 100MG
BEVESPI AEROSPHERE 9MCG-4.8MCG	EXELOX (G) 9.5MG/24HR	LIPITOR (G) 10MG	RYBELSUS 3MG	XARELTO 2.5MG
BEYAZ	EXFORGE (G) 13.3MG/24HR	LIPITOR (G) 20MG	RYBELSUS 7MG	XARELTO 10MG
BIJUVA 1MG-100MG	EXFORGE (G) 5/160MG	LIPITOR (G) 40MG	RYBELSUS 14MG	XARELTO 15MG
BIKTARVY	EXFORGE (G) 5/320MG	LIPITOR (G) 80MG	SAPHRIS 5MG	XARELTO 20MG
50MG-200MG-25MG	EXFORGE (G) 10/160MG	LUMIGAN 0.01%	SAPHRIS 10MG	XELJANZ 5MG
BINOSTO 70MG	EXFORGE (G) 10/320MG	MESTINON TS 180MG	SEASONIQUE 0.15/0.03/0.01MG	XELJANZ 10MG
BREO ELLIPTA 100/25MCG	EXFORGE HCT 160/12.5/5MG	MICARDIS 40MG	SENSIPAR (G) 30MG	XELJANZ XR 11MG
BREO ELLIPTA 200/25MCG	EXFORGE HCT 160/12.5/10MG	MICARDIS 80MG	SENSIPAR (G) 60MG	XENICAL 120MG
BREZTRI AEROSPHERE 160MCG-9MCG-4.8MCG	EXFORGE HCT 160/25/5MG	MICARDIS HCT 40/12.5MG	SEREVENT DISKUS 50MCG	XIGDUO XR 5/1000MG
BRILINTA 60MG	EXFORGE HCT 160/25/10MG	MICARDIS HCT 80/12.5MG	SIMBRINZA 1%/0.2%	XIGDUO XR 10/500MG
BRILINTA 90MG	EXFORGE HCT 320/25/10MG	MINIPRESS (G) 1MG	SINGULAIR (G) 10MG	XIGDUO XR 10/1000MG
BYSTOLIC (G) 2.5MG	FARXIGA 5MG	MINIPRESS (G) 2MG	SINGULAIR GRANULES (G) 4MG	YASMIN 28 (G)
BYSTOLIC (G) 5MG	FARXIGA 10MG	MINIPRESS (G) 5MG	SLYND 4MG	YAZ (G) 3/0.02MG
BYSTOLIC (G) 10MG	FETZIMA 20MG	MICARDIS 80MG	SOOLANTRA 1%	ZELAPAR 1.25MG
BYSTOLIC (G) 20MG	FETZIMA 40MG	MICARDIS HCT 80/25MG	SPIRIVA 18MCG	ZIANA 1.2%-0.025%
	FETZIMA 80MG	MINIPRESS (G) 1MG	SPIRIVA RESPIMAT 2.5MCG	ZYCLARA PACKET 3.75%
	FETZIMA 120MG	MINIPRESS (G) 2MG	STALEVO (G) 50MG	ZYCLARA PUMP 3.75%
		MINIPRESS (G) 5MG	STALEVO (G) 100MG	ZYTIGA (G) 500MG

NOTE: Medication names appearing with (G) are available in a Generic version from your local or U.S. mail order pharmacy. This list is subject to change. Please call 1-866-893-6337 toll free to verify the availability of your medication through this program.

Altus Dental Insurance Company, Inc.
PO Box 1557
Providence, RI 02901-1557
877-223-0588

GROUP INFORMATION		To be completed by Human Resources or Benefit Administrator.	
Employer / Group Name		Group No.	
Dental Division No.	Vision Division No.	Date of Hire	Location No. (if applicable)

I. SUBSCRIBER INFORMATION

Subscriber Name (First, Last)	Date of Birth (MM/DD/YYYY)	Social Security / I.D. #	
Street Address / P.O. Box No.	Apt. No.	City	State Zip
Preferred Mobile Number	Preferred Email		

II. ENROLLMENT INFORMATION

Effective Date of Action (MM/DD/YYYY)	TYPE OF COVERAGE <i>Check all that apply.</i>		Dental Low Plan	Vision
			Dental High Plan	
QUALIFYING EVENT	<input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire/Re-hire	<input type="checkbox"/> Marriage <input type="checkbox"/> Divorce	<input type="checkbox"/> Birth or Adoption <input type="checkbox"/> Workers' Compensation	<input type="checkbox"/> Return from Leave of Absence <input type="checkbox"/> Loss of Coverage
ACTION CODE <i>Check one.</i>	<u>ADDITIONS</u> <input type="checkbox"/> New Subscriber <input type="checkbox"/> Add Dependent to Family <input type="checkbox"/> Reinstatement	<u>TERMINATION</u> <input type="checkbox"/> Remove Subscriber <input type="checkbox"/> Remove Dependent <i>List name in Section III</i>	<u>STATUS CHANGE</u> <input type="checkbox"/> Name / Address Change <input type="checkbox"/> Transfer from Division # _____ to # _____ <input type="checkbox"/> Change Type of Coverage	<u>COBRA</u> <input type="checkbox"/> Reinstatement of Subscriber <input type="checkbox"/> Addition of Dependent Prior ID # _____

III. DEPENDENT INFORMATION

First Name	Last Name (if different)	Date of Birth (MM/DD/YYYY)	Relationship	Enroll In:	
				Dental	Vision
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>

I certify that all information is correct to the best of my knowledge. I understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with underwriting guidelines. If my employer requires employee contributions for this coverage, I authorize the deductions of these amounts from my wages periodically.

Employee Signature

Date

Benefits Administrator Authorization

Date

NOTICE OF NONDISCRIMINATION AND ACCESSIBILITY POLICY

Altus Dental does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-223-0588.

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-223-0588.

MSHG - TOWN OF WEBSTER PREVENTIVE PLAN

Group Number: 6401

Altus Dental Plus - Includes Connection Dental and DenteMax Networks

Annual Maximum

\$500

Maximum Lifetime Cap

Unlimited

Deductible

Individual \$0

Family \$0

Dependent Coverage

Dependent children are covered under these benefits up until the end of the month that they turn 26.

Plan pays 100%; Member Coinsurance 0%

- Oral exam twice per calendar year
- Cleaning two per calendar year
- Fluoride treatment for children under age 19 twice per calendar year
- Bitewing x-rays one set per calendar year
- Complete x-ray series or panoramic film once every 36 months.
- Single x-rays as required
- Sealants for children under age 16, once every 36 months on unrestored permanent molars

Monthly Premium effective 7/1/24 - 6/30/26:

Individual: \$20.00 Two Person: \$40.00 Family: \$70.00

P Pre-treatment Estimate
Recommended

A Prior Authorization
Required

See back page for additional
information



This is a summary of benefits. The information shown here is not a guarantee of payment. Refer to the Certificate of Coverage for the full plan terms. The Certificate includes any limitations or exclusions not seen here. For a complete listing of frequencies and limitations go to www.altusdental.com/el. To be covered, services must be dentally necessary and appropriate as per our review guidelines.

Note: This plan does not include a missing tooth clause. In addition, if covered, crowns, bridges, partials and complete dentures are paid when the permanent structure is inserted (seated) by the dentist. Member coverage must be active on the date that the permanent structure is inserted and payment is based on benefits available on that day — for example, if the member's annual maximum has been paid prior to the insertion of the permanent structure, the service will not be paid.

* Time limits on services (e.g. 6, 12, 24, 36, or 60 months) are figured to the exact day. Services are then covered the following day. For example, when a service is covered once every 12 months, if the service was done on July 1, it will not be covered again until the following year on July 2 or after.

Out-of-Network Coverage

You have the freedom to choose any dentist, but it is important to know that your out-of-pocket costs may be higher when you visit a dentist who does not participate in our network. Non-participating dentists have not agreed to accept the Altus Dental allowance as payment in full, so services from an out-of-network dentist may cost you more. You may also have to pay the dentist at the time of service and file a claim yourself. To be eligible, all claims must be filed within one year of the date of service. To find a participating dentist near you, use our Find A Dentist tool at www.altusdental.com.

How to Find a Dentist

Choose from Altus Dental's extensive network of dentists, you're sure to find one that's right for you. Visit www.altusdental.com to use our online Find A Dentist tool. You can see if your current dentist participates with us or look for a new dentist by searching by name, location or specialty. Enter your address or other criteria important to you (extended hours, languages spoken, etc.), and our tool will return a list of dentists that meet your needs – as well as maps and driving directions.

Beyond Benefits

When you visit us at www.altusdental.com, you can access a wealth of important dental health information and manage your plan by:

- Checking your benefits and claims
- Reviewing your deductibles and maximums
- Using our Find A dentist tool to find a dentist in your area

Notice of Nondiscrimination and Accessibility Policy

Altus Dental does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-223-0588.

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-223-0588.

MSHG - TOWN OF WEBSTER LOW

Group Number: 6401-0001

Altus Dental Plus - Includes Connection Dental and DenteMax Networks

Exams, cleanings, bitewing x-rays, single x-rays, fluorides, sealants and full mouth/Panorex x-rays don't count against your annual maximum.

Annual Maximum

\$1,500

Maximum Lifetime Cap

Unlimited

Deductible

Individual \$0

Family \$0

Dependent Coverage

Dependent children are covered under these benefits up until the end of the month that they turn 26.

P Pre-treatment Estimate Recommended

A Prior Authorization Required

See back page for additional information

Plan pays 100%; Member Coinsurance 0%

- Oral exam twice per calendar year
- Cleaning three per calendar year
- Fluoride treatment for children under age 19 twice per calendar year
- Bitewing x-rays one set per calendar year
- Complete x-ray series or panoramic film once every 36 months.
- Single x-rays as required
- Sealants for children under age 16, once every 36 months on unrestored permanent molars
- Space maintainers unilateral space maintainers once per lifetime for lost deciduous (baby) teeth. Bilateral space maintainers once every 60 months for lost deciduous (baby) teeth
- Periodontal maintenance following active therapy two per year

Plan pays 80%; Member Coinsurance 20%

- Palliative treatment (minor procedures necessary to relieve acute pain) twice per calendar year
- Amalgam (silver) fillings and composite (white) fillings
- Extractions and other routine oral surgery when not covered by a patient's medical plan
- General anesthesia or intravenous (I.V.) sedation for certain complex surgical procedures
- Root canal therapy on permanent teeth one procedure per tooth per lifetime.
- P • Root planing and scaling once per quadrant every 24 months
- P • Osseous (bone) surgery once per quadrant every 24 months (bone grafts are not covered)
- P • Gingivectomies once per site every 24 months
- P • Soft tissue grafts once per site every 60 months
- P • Crown lengthening once per site every 60 months
- Repairs to existing partial or complete dentures once per calendar year
- Recementing crowns or bridges once every 60 months
- Rebasing or relining of partial or complete dentures once every 60 months

Plan pays 50%; Member Coinsurance 50%

- P • Crowns over natural teeth, build ups, posts and cores replacement limited to once every 60 months
- P • Bridges and crowns over implants replacement limited to once every 60 months
- P • Partial and complete dentures replacement limited to once every 60 months
- P • Surgical placement of endosteal implant and abutment replacement limited to once every 60 months

Monthly Premium effective 7/1/24 - 6/30/26:

Individual: \$40.58 Two Person: \$81.16 Family: \$123.52

This is a summary of benefits. The information shown here is not a guarantee of payment. Refer to the Certificate of Coverage for the full plan terms. The Certificate includes any limitations or exclusions not seen here. For a complete listing of frequencies and limitations go to www.altusdental.com/el. To be covered, services must be dentally necessary and appropriate as per our review guidelines.

Note: This plan does not include a missing tooth clause. In addition, if covered, crowns, bridges, partials and complete dentures are paid when the permanent structure is inserted (seated) by the dentist. Member coverage must be active on the date that the permanent structure is inserted and payment is based on benefits available on that day — for example, if the member's annual maximum has been paid prior to the insertion of the permanent structure, the service will not be paid.

* Time limits on services (e.g. 6, 12, 24, 36, or 60 months) are figured to the exact day. Services are then covered the following day. For example, when a service is covered once every 12 months, if the service was done on July 1, it will not be covered again until the following year on July 2 or after.

Out-of-Network Coverage

You have the freedom to choose any dentist, but it is important to know that your out-of-pocket costs may be higher when you visit a dentist who does not participate in our network. Non-participating dentists have not agreed to accept the Altus Dental allowance as payment in full, so services from an out-of-network dentist may cost you more. You may also have to pay the dentist at the time of service and file a claim yourself. To be eligible, all claims must be filed within one year of the date of service. To find a participating dentist near you, use our Find A Dentist tool at www.altusdental.com.

How to Find a Dentist

Choose from Altus Dental's extensive network of dentists, you're sure to find one that's right for you. Visit www.altusdental.com to use our online Find A Dentist tool. You can see if your current dentist participates with us or look for a new dentist by searching by name, location or specialty. Enter your address or other criteria important to you (extended hours, languages spoken, etc.), and our tool will return a list of dentists that meet your needs – as well as maps and driving directions.

Beyond Benefits

When you visit us at www.altusdental.com, you can access a wealth of important dental health information and manage your plan by:

- Checking your benefits and claims
- Reviewing your deductibles and maximums
- Using our Find A dentist tool to find a dentist in your area

Notice of Nondiscrimination and Accessibility Policy

Altus Dental does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-223-0588.

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-223-0588.

MSHG - TOWN OF WEBSTER HIGH

Group Number: 6401-0002

Altus Dental Preferred Point of Service Option - Includes Connection Dental and DenteMax Networks

Exams, cleanings, bitewing x-rays, single x-rays, fluorides, sealants and full mouth/Panorex x-rays do not count against your annual maximum.

Annual Maximum

\$1,750

Elective Orthodontic Lifetime Maximum

\$1,000

Maximum Lifetime Cap

Unlimited

In-Network Deductible

Individual \$0

Family \$0

Out-of-Network Deductible

Individual \$50

Family \$150

Dependent Coverage

Dependent children are covered under these benefits up until the end of the month that they turn 26.

P Pre-treatment Estimate Recommended

A Prior Authorization Required

See back page for additional information

In Network: Plan pays 100%; Member Coinsurance 0%

Out of Network: Plan pays 100%; Member Coinsurance 0%

- Oral exam twice per calendar year
- Cleaning three per calendar year
- Fluoride treatment for children under age 19 twice per calendar year
- Bitewing x-rays one set per calendar year
- Complete x-ray series or panoramic film once every 36 months.
- Single x-rays as required
- Sealants for children under age 16, once every 36 months on unrestored permanent molars
- Space maintainers unilateral space maintainers once per lifetime for lost deciduous (baby) teeth. Bilateral space maintainers once every 60 months for lost deciduous (baby) teeth

In Network: Plan pays 100%; Member Coinsurance 0%

Out of Network: Plan pays 80%; Member Coinsurance 20% - (Deductible Applies)

- Palliative treatment (minor procedures necessary to relieve acute pain) twice per calendar year
- Amalgam (silver) fillings and composite (white) fillings
- Extractions and other routine oral surgery when not covered by a patient's medical plan
- General anesthesia or intravenous (I.V.) sedation for certain complex surgical procedures
- Root canal therapy on permanent teeth one procedure per tooth per lifetime.
- P • Root planing and scaling once per quadrant every 24 months
- P • Osseous (bone) surgery once per quadrant every 24 months (bone grafts are not covered)
- P • Gingivectomies once per site every 24 months
- P • Soft tissue grafts once per site every 60 months
- P • Crown lengthening once per site every 60 months
- Repairs to existing partial or complete dentures once per calendar year
- Recementing crowns or bridges once every 60 months
- Rebasing or relining of partial or complete dentures once every 60 months
- Periodontal maintenance following active therapy two per year

In Network: Plan pays 60%; Member Coinsurance 40%

Out of Network: Plan pays 50%; Member Coinsurance 50% - (Deductible Applies)

- P • Crowns over natural teeth, build ups, posts and cores replacement limited to once every 60 months
- P • Bridges and crowns over implants replacement limited to once every 60 months
- P • Partial and complete dentures replacement limited to once every 60 months
- P • Surgical placement of endosteal implant and abutment replacement limited to once every 60 months

In Network: Plan pays 50%; Member Coinsurance 50%

Out of Network: Plan pays 50%; Member Coinsurance 50%

- P • Elective braces and related services for dependent children under the age of 19. Subject to a lifetime maximum. No pre-approval required.

Monthly Premium effective 7/1/24 - 6/30/26:

Individual: \$51.86 Two Person: \$103.74 Family: \$161.94

This is a summary of benefits. The information shown here is not a guarantee of payment. Refer to the Certificate of Coverage for the full plan terms. The Certificate includes any limitations or exclusions not seen here. For a complete listing of frequencies and limitations go to www.altusdental.com/el. To be covered, services must be dentally necessary and appropriate as per our review guidelines.

Note: This plan does not include a missing tooth clause. In addition, if covered, crowns, bridges, partials and complete dentures are paid when the permanent structure is inserted (seated) by the dentist. Member coverage must be active on the date that the permanent structure is inserted and payment is based on benefits available on that day — for example, if the member's annual maximum has been paid prior to the insertion of the permanent structure, the service will not be paid.

* Time limits on services (e.g. 6, 12, 24, 36, or 60 months) are figured to the exact day. Services are then covered the following day. For example, when a service is covered once every 12 months, if the service was done on July 1, it will not be covered again until the following year on July 2 or after.

Out-of-Network Coverage

You have the freedom to choose any dentist, but it is important to know that your out-of-pocket costs may be higher when you visit a dentist who does not participate in our network. Non-participating dentists have not agreed to accept the Altus Dental allowance as payment in full, so services from an out-of-network dentist may cost you more. You may also have to pay the dentist at the time of service and file a claim yourself. To be eligible, all claims must be filed within one year of the date of service. To find a participating dentist near you, use our Find A Dentist tool at www.altusdental.com.

How to Find a Dentist

Choose from Altus Dental's extensive network of dentists, you're sure to find one that's right for you. Visit www.altusdental.com to use our online Find A Dentist tool. You can see if your current dentist participates with us or look for a new dentist by searching by name, location or specialty. Enter your address or other criteria important to you (extended hours, languages spoken, etc.), and our tool will return a list of dentists that meet your needs – as well as maps and driving directions.

Beyond Benefits

When you visit us at www.altusdental.com, you can access a wealth of important dental health information and manage your plan by:

- Checking your benefits and claims
- Reviewing your deductibles and maximums
- Using our Find A dentist tool to find a dentist in your area

Notice of Nondiscrimination and Accessibility Policy

Altus Dental does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-223-0588.

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-223-0588.



Preventive Rewards Program

Nothing is more important to us than your oral health. That's why we've introduced the Preventive Rewards Program. When you choose this benefit enhancement, none of your preventive dental services count toward your annual maximum, allowing you to stretch your benefit dollars.

Here's how the Preventive Rewards Program works:

- Let's say your annual maximum is **\$1,500**.
- Each year, you receive:
 - Two cleanings**
 - Two exams**
 - X-rays**
 - Fluoride Treatment**
 - Sealants**
- At the end of the year, your annual maximum **remains \$1,500**

Example only. Refer to your specific coverage.

The savings add up

Wondering how preventive benefits affect your annual maximum? Here's an example:

	Without Option	With Option
ANNUAL MAXIMUM	\$1,500	\$1,500
FIRST EXAM	\$30	\$30
SECOND EXAM	\$30	\$30
FIRST CLEANING	\$78	\$78
SECOND CLEANING	\$78	\$78
X-RAYS (FULL MOUTH)	\$105	\$105
FLUORIDE TREATMENT	\$25	\$25
SEALANTS (4)	\$184	\$184
REMAINING MAXIMUM	\$970	\$1,500

**This example is based on preventive benefits covered at 100%. Please refer to your benefit summary for details on your specific coverage.*

That's it – no criteria to meet and this benefit enhancement is yours every year.



Why preventive services matter

Your mouth is a window to your body. Diseases such as cancer, heart disease, kidney disease and diabetes can sometimes be identified by your dentist during preventive services like routine dental exams, cleanings and x-rays.

Prevention plays a key role in good oral health, and that can lead to good overall health. Ask about our Preventive Rewards Program today.

Benefits Summary: Altus Vision™ - 150

Benefit	Description	Copay
In-Network Coverage with VSP Choice Network: 45,000 Preferred Providers 117,000 Access Points		
WELLVISION® EXAM		
Exams 1 exam every 12 months	<ul style="list-style-type: none"> Comprehensive eye exam to ensure overall visual wellness 	\$10
PRESCRIPTION GLASSES		
Frames 1 pair every 24 months	<ul style="list-style-type: none"> \$150 allowance for wide selection of frames 20% savings on amount over allowance. Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied Frame allowance backed by a wholesale guarantee, meaning VSP fully covers more frames than retail allowance plans Allowance may differ at Costco® Optical, however it is of equivalent value. Costco® Optical allowance of \$80 is equivalent to \$150 frame allowance at VSP doctor locations and participating retail chains 	\$25
Lenses 1 pair every 12 months	<ul style="list-style-type: none"> Single vision, lined bifocal, lined trifocal, and lenticular lenses 	
Covered Lens Enhancements	<ul style="list-style-type: none"> Impact-resistant lenses for children Standard Progressive Lenses 	\$0
CONTACT LENSES (instead of glasses)		
Contacts Every 12 months	<ul style="list-style-type: none"> \$150 allowance for contacts Contact lens fitting and evaluation 	\$0 Up to \$60
VALUE-ADDED PROGRAMS		
VSP Essential Medical Eye Care Program	<ul style="list-style-type: none"> Exams and services to treat immediate issues like pink eye and sudden changes in vision Treatment options to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more Members with diabetes who do not have diabetic eye disease receive full retinal screening at no cost. Members with diabetic eye disease, glaucoma, and age-related macular degeneration (AMD) receive additional exams and services with \$20 copay. Limitations and coordination with medical coverage may apply. Ask your VSP network doctor for details 	
Extra Savings		
Additional Lens Enhancements	<ul style="list-style-type: none"> Average savings of 30% on enhancements including tints, UV protection, scratch-resistant coating, anti-glare coating and more Discount rate for Premium Progressive Lenses: \$95-\$105; Custom Progressive Lenses: \$150-\$175 	
Featured Frames	<ul style="list-style-type: none"> Extra \$20 allowance on featured brands like bebe®, Calvin Klein, Flexon®, Lacoste, Nike, and more. Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change. Not applicable at Costco® Optical. Ask your VSP network doctor for more details 	
Additional Glasses and Sunglasses	<ul style="list-style-type: none"> 20% savings on additional prescription or non-prescription glasses and/or sunglasses from any VSP provider within 12 months of last WellVision Exam 	
Laser Vision Correction	<ul style="list-style-type: none"> Average 15%-20% savings. See VSP.com for more information 	
TruHearing®¹	<ul style="list-style-type: none"> Save up to 60% on the latest brand-name hearing aids. Visit TruHearing.com/VSP or call 877.396.7194 for more information 	
Monthly Rates		
Employee Only	Employee & Spouse	Employee & Child(ren)
\$5.05	\$10.10	\$12.96
Family		
\$19.81		

See reverse side for more information.

Your Coverage with Out-of-Network Providers:

Exam	Up to \$55	Lined Bifocal Lenses	Up to \$50	Progressive Lenses	Up to \$50
Frame	Up to \$70	Lined Trifocal Lenses	Up to \$65	Elective Contact Lenses & Fitting/Evaluation Fees	Up to \$120
Single Vision Lenses	Up to \$30	Lenticular Lenses	Up to \$100	Necessary Contact Lenses	Up to \$210

Items Not Covered

The following items are excluded unless otherwise stated in the Benefits Summary: plano lenses (refractive correction of less than $\pm .50$ diopter); two pairs of glasses instead of bifocals; replacement of lenses, frames, or contacts; medical or surgical treatment; orthoptics, vision training or supplemental testing; local, state and/or federal taxes, except where VSP is required by law to pay.

Items not covered under contact lens coverage: insurance policies or service agreements; artistically painted or non-prescription lenses; fitting and evaluation fees for corneal refractive therapy, orthokeratology, and myopia management; re-fitting of contact lenses after the initial (90-day) fitting period; additional office visits for contact lens pathology; contact lens modification, polishing or cleaning.

Dependent Coverage

Dependent children are covered through the end of the month they turn age 26.

Notice of Nondiscrimination and Accessibility Policy

Altus Dental does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

Llame al 1-877-223-0588.

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis.

Ligue para 1-877-223-0588.

VSP and WellVision Exam are registered trademarks of Vision Service Plan. Flexon is a registered trademark of Marchon Eyewear, Inc. All other brands or marks are the property of their respective owners.

Coverage with a retail chain may be different or not apply. Log in to vsp.com to check your benefits for eligibility and to confirm in-network locations based on your plan type. VSP guarantees coverage for covered services from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

1 VSP is providing information to its members, but does not offer or provide any discount hearing program. The relationship between VSP and TruHearing is that of independent contractors. VSP makes no endorsement, representations, or warranties regarding any products or services offered by TruHearing, a third-party vendor. The vendor is solely responsible for the products or services offered by them. If you have any questions regarding the services offered here, you should contact the vendor directly.

TruHearing offers individuals the opportunity to purchase hearing aids at discounted prices, including individuals covered by self-funded health plans not subject to state insurance or health plan regulations. TruHearing is not insurance and not subject to state insurance regulations. TruHearing provides discounts to certain healthcare groups for hearing aid sales and services; TruHearing provides fitting, programming, and three adjustment visits at no cost; the member is obligated to pay for testing, and all post-fitting hearing care services, but will receive a discount from those healthcare providers who have contracted with TruHearing. Not available directly from VSP in the states of Washington and California.

Altus Vision™ is underwritten by Altus Dental Insurance Company. Claims processing, claims service, and provider network administration for Altus Vision™ are provided under contract by Vision Service Plan Insurance Company ("VSP").



CAFETERIA PLAN ADVISORS

Tel.: 781-848-9848

New Hire / Change in Status Form

Flexible Spending Pre-Tax Payroll Reduction Authorization

Town of Webster

INSTRUCTIONS: Complete & return this form to Courtney Friedland, **Town of Webster, within 30 days** of date of hire or date of qualified event.

H.R. Use Only:

First P/R Deduction Date: _____

Per Pay-Period Amount: \$ _____

1 Personal Information:

Participant Name: _____

Date of Hire -or- Date of Qualified Change Event through 6/30/2025
(Expenses must be incurred between these dates.)

Mailing Address: _____

Social Security No.: _____

City/Town, State: _____ **ZIP:** _____

Date of Birth: _____

E-Mail: _____

Daytime Phone: _____

personal
 work

2 I work for (check one): Town Schools → **I am paid (check one):** Weekly 52 Weekly 39 Bi-weekly w/Lump

3 Date of Hire or Qualified Change Event: _____

4 Eligibility Event (check one): New Hire Marriage
 Return from Leave of Absence

Divorce Birth/Adoption
 Other: _____

5 New Benefit Elections for REMAINDER of the Plan Year:

FSA Health Care Account (\$3,200 maximum)

For eligible health, dental, and vision expenses. Any unspent balance for the plan year—**up to \$640**—can roll over to the next plan year provided you re-enroll in the Health Care FSA for that new plan year. Benefit card included.

Ineligibility Notice: If you or your spouse have a Health Savings Account (HSA), you are not eligible to participate in the Health Care FSA plan.

Election for Remainder of Plan Year: \$ _____

FSA Dependent Care Account (\$5,000 maximum per family)

For qualified day care expenses for eligible dependents (as defined by the IRS) under age 13, elderly dependents, and dependents with special needs. Confirm eligibility prior to enrolling. Claim-based reimbursement plan (no benefit card); participants must submit claim(s) each plan year to receive accrued funds.

Election for Remainder of Plan Year: \$ _____

6 Certification. I hereby authorize a salary reduction agreement for the amount(s) shown above and understand that:

- This election cannot be revoked or changed during the plan year unless the participant experiences a qualifying event as defined by the IRS.
- Participants must re-enroll each plan year; re-enrollment is not automatic. Similarly, Dependent Care claims must be submitted each plan year.
- Health Care FSA cards reload at the start of each plan year each time you re-enroll; to avoid a new card fee do not discard your cards until they expire, even if you take a break from the plan.
- Cafeteria Plan Advisors will hold these funds until eligible expenses are incurred and a claim is submitted. Funds may be forfeited in accordance with Internal Revenue Service (IRS) Publication 969 if eligible expenses are not spent or submitted for reimbursement by plan year deadline or purchased utilizing the provided debit card (if applicable) within the plan year or the date upon which employment ends, whichever comes first.
- FSA expenses must be consistent with allowable deductions under IRS Publication 969.
- Your Health Care FSA plan has a **Rollover option**. Eligible balances roll over to the next plan year when you re-enroll in the Health Care FSA for the new plan year, and the rollover occurs after the current plan year's 90-day run-out/claim submission period has ended.
- All claims for the Plan Year must be submitted within ninety (90) days of the end of Plan Year.
- Additional certification for Dependent Care Plan Participants: I understand that the Dependent Care Reimbursement Plan Guidelines can be found at CPA125.com and I qualify to participate in the FSA Dependent Care plan. I agree to notify the plan administrator in writing within 30 days should I experience a change in need or no longer meet the IRS's eligibility criteria. Dependents must qualify under regulations set forth in IRC sections 152 and 129.
- **Tax advice:** It is suggested you consult with a tax advisor to determine your tax savings and/or limits on tax deductions.

► **Signature:** _____

Date: _____

Human Resources: Send completed form to Caf. Plan Advisors via fax (781-848-8477) or e-mail (info@cpa125.com).



Flexible Spending Benefits

Town of Webster

One of the Few Gifts the IRS Gives!

Discover the benefit that **SAVES YOU MONEY**. This perk allows you to set aside a portion of your pay—**BEFORE TAXES**—to cover out-of-pocket expenses in these categories:

- ◆ **HEALTH CARE.*** Eligible expenses and services include: non-cosmetic medical, dental, and vision care services; prescription medications; over-the-counter 'medicines' (not vitamins or supplements); orthodontics; prescription eyeglasses, contact lenses, laser eye surgery; mental health services; alternative health therapies (e.g. chiropractic, acupuncture), and **MORE!**

Max. Annual Health Care Election: \$3,200.

Who's Covered? You, your legal spouse, and your dependents as defined by the Internal Revenue Service, including those claimed on your tax return and adult children under age 26.

Benefit Cards. New Health Care FSA enrollees will receive **2 cards** that can be used at most medical facilities, dental offices, optical shops, and pharmacies to pay for eligible expenses. **Keep your cards!** They will reload each plan year that you enroll.

Rollover Option. Health Care FSA balances—**up to \$640**—will roll over to the next plan year as long as you re-enroll for that new plan year. Funds roll over after the prior plan year's 90-day claim submission ("run out") deadline. *(Note: The max. rollover for the 2023-2024 plan year is \$610; re-enrollment is required for funds to roll over.)*

HSA Ineligibility. If you or your spouse have a Health Savings Account ('HSA'), you are **NOT ELIGIBLE** to participate in the Health Care FSA plan.

- ◆ **DEPENDENT CARE.**** For qualified **day care** expenses for eligible dependents (as defined by the IRS) under age 13, elderly dependents, and dependents with special needs. Eligible expenses include daycare, preschool, before/after school care, day camp, elder daycare. *Claim-based reimbursement plan (no benefit card); participants must submit claim(s) each plan year to receive accrued funds.*

Max. Annual Dep. Care Election: \$5,000 per family.



Enroll by 5/17/2024
for the
7/1/2024 – 6/30/2025
Plan Year***

Already in the FSA Plan?

Re-enrollment is NOT automatic!

► **Re-enroll** via your online account portal—not the mobile app! Go to cpaemployee.lh1ondemand.com and log-in on the LEFT side of the sign-in screen. On your account homepage, click the blue *Enroll/Re-enroll* button and follow the steps to enroll for the new plan year. Be sure to click *Submit* at the end of the process. (We suggest printing or saving your enrollment confirmation.)

► **New to the FSA Plan?** Complete the "Authorization for Pre-Tax Payroll Reduction" form and return it to **Courtney Friedland** (e-mail: ctyrrell@webster-ma.gov) by the deadline date.

Track Your Account and File Claims 24/7!

Log in to your **employee portal** via our website (www.CPA125.com), or use our app: **CPA Flex Mobile**.



The annual FSA admin. fees are paid by your employer, so you save even more!

* Not all Health Care expenses are FSA-eligible, such as: cosmetic procedures or products (e.g. Botox, teeth whitening, veneers, etc.), couples/family counseling, general health/wellness expenses (i.e., toothbrushes, toothpastes, non-prescription sunglasses, gym dues, etc.), and federally non-permissible products. Some healthcare-related expenses, such as medical equipment and some services, may require a physician's Letter of Medical Necessity in order to be FSA-eligible. Visit <https://fsastore.com/CPAEligibility> for more info. on specific products and services.

** Overnight camp and school tuition for kindergarten and above are not FSA-eligible; day camp is eligible when utilized as a form of childcare in order for the parent(s)/guardian(s) to be able to work; extra-curricular and enrichment programs/activities that aren't daycare/childcare-based are not eligible; money paid to a childcare provider who doesn't report it as income on their taxes is not FSA-eligible.

*** Cafeteria Plan Advisors holds flex-spending (FSA) funds until eligible expenses are incurred and claim(s) submitted. Funds may be forfeited in accordance with IRS Publication 969 if eligible expenses are not incurred by the plan year deadline through the use of the provided debit card (if applicable) or claim submission, or the date upon which employment ends, whichever comes first.



Don't know how to spend your FSA money?

Did you know you could use your FSA to save money on everyday health essentials like baby health items, health trackers, pain relief products and more?

Use your FSA funds or risk forfeiting your money.



The largest selection
of guaranteed
FSA-eligible products



24/7 support
FREE shipping on
orders over \$50



**Are your health
needs eligible?**
Easily check with our
expansive Eligibility List



No Rx needed
Over-the-counter
meds are fully eligible



Learning Center
Get daily money-
saving info



Use your FSA card
or any major credit card

**\$10
OFF \$100+**

One use per customer
Exp. 1/1/23

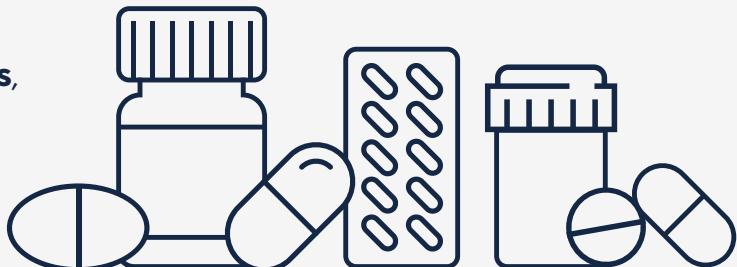
Want 10 bucks to spend on your health?

Visit **FSAstore.com/CPAFlyer**

and use code **CPA10** at checkout.

Now Eligible: Over-the-Counter Medicines

Now you can get the relief you need from **fully eligible over-the-counter (OTC) medicines**, with no prescription required. Use your funds to plan ahead with OTC medicine from pain relief to allergy and sinus, cold and flu and more!



100% eligible OTC medicines: buy the essentials you need with no hassle



Shop with your FSA card or any major credit card



The largest selection of guaranteed FSA-eligible products



Questions? **Access 24/7 support (call or chat)**

**\$10
OFF \$100+**

One use per customer
Exp. 1/1/23

Want \$20 to spend on your health?
Visit **FSAstore.com/CPAOTC** and
use code **CPAOTC10** at checkout.

New OTC Expenses Now Eligible For Your FSA Funds

When you participate in a Flexible Spending Account (FSA), you're able to contribute pre-tax funds for use on hundreds of eligible expenses. Recently, you gained even more flexibility in your ability to save when the CARES Act was signed into law.

This new legislation expanded the list of expenses that are considered eligible by **including popular over-the-counter products**, which consumers can now purchase with their FSA without a prescription. This change went into effect on January 1, 2020, and allows over 20,000 new expenses as eligible moving forward. That's great news for consumers, since the average American shops for over-the-counter medications 26 times each year.

Here are five of the most common expenses that are now eligible to use FSA funds without a prescription.

Pain relief medications

Headaches. Muscle soreness. Sprains. There are so many reasons to need pain relievers. There are two common types of over-the-counter pain medications: acetaminophen and nonsteroidal anti-inflammatory drugs (NSAIDs), both of which are now among the eligible expenses available from an FSA.

Cold and flu products

Winter may be behind us, but cold and flu season never really goes away. As much as 20 percent of the U.S. population gets the flu, on average each season. Fortunately, the over-the-counter medicines taken to cope with a severe cough or congestion are now eligible expenses.

Allergy products

Thirty percent of American adults and 40 percent of children suffer from allergies. And the cost of allergies to the healthcare system is estimated at \$18 billion. Those who do have allergies can now find relief with their HSA and FSA funds in the form of over-the-counter antihistamines and decongestants.

Heartburn medications

Heartburn is among the more common afflictions in this country. That's why Americans spend billions of dollars each year on medicines that treat heartburn. The CARES Act means that these over-the-counter drugs are FSA eligible without a prescription.

Menstrual products

The CARES Act also included menstrual care products as eligible expenses for FSAs. Eligible products include tampons, pads and menstrual sponges.

How do I know what qualifies?

- Consumers can simply scan a product bar code right in their mobile app to help determine eligibility as a qualified medical expense. That's peace of mind with a touch of a button.
- Online shopping for eligible expenses can be done on sites like FSA Store. This site is dedicated to items that are eligible under pre-tax accounts like FSAs.

How it Works: Use the Debit Card: Once retailers have updated their payment systems and inventories consumers can simply use their card to pay for these newly eligible items, but they should still remember to save their receipts in case the purchase needs to be verified later. Submit a Claim: Consumers can submit claims for reimbursement through their online account or using the mobile app.





Important Information About Your PREPAID BENEFITS CARD

If you're newly enrolled in the Flexible Spending Account Program, you will automatically receive the new blue Prepaid Benefits Card. You'll receive two cards at your home address for you and your family members to use. The Cards will arrive in a special envelope that looks like this – so please don't throw it out!



Your Prepaid Benefits Card is loaded with the value of your annual FSA\HSA election amount (less any amounts you have already spent in this plan year.) Using your Card helps you keep cash in your wallet and makes accessing your FSA funds easy. The Card can be used, instead of cash, to pay for qualified health care expenses such as:

- Prescription and health plan copayments, deductibles and coinsurance
- “Amount Due” on medical and dental statements
- Orthodontics
- Mail-order or online prescription invoices
- Vision services and eyeglasses
- LASIK surgery
- Eligible over-the-counter (OTC) items

You'll simply swipe your Card each time you incur a qualified health care expense and the amount of your purchase will be deducted from your FSA – automatically. You can also fill in your Card number on bills you receive from providers to pay the amount you owe. You'll have no claim forms to complete and you won't have to wait to get a check in the mail. You can check balances or account details anytime – online at www.cpa125.com or via the mobile app -- **CPA FLEX MOBILE**. It's that easy!

It's Important to Save Your Receipts!

Your Prepaid Benefits Card will definitely improve your cash flow. However, be aware that the IRS requires the Card be used only for eligible expenses. Most of the time, we can verify the eligibility of the expense automatically. Yet, there are instances when you'll receive a letter/notification asking you to furnish an itemized receipt to verify the expense. When you receive such a request, make sure you submit the receipts as soon as possible to avoid having your Card suspended until receipts have been submitted and approved.

What is an itemized receipt?

An itemized receipt must include: merchant or provider name, services received or item purchased, date of service, and amount of the expense. Cancelled checks, handwritten receipts, card transaction receipts or previous balance receipts cannot be used to verify an expense.

Using Your Card is as Easy as 1-2-3!

Look for additional information about how to use your new Prepaid Benefits Cards included with your card packet in the mail. We hope you enjoy this new exciting feature of your plan! Remember, the Card will not work at gas stations or restaurants – only at health care related providers.

Save your card. Every year you re-enroll, the funds get loaded on to this card!

Cafeteria Plan Advisors, Inc.
420 Washington Street, Suite 100, Braintree, MA 02184 781.848.9848 www.cpa125.com



EMPLOYEE BENEFITS SUMMARY | 50019104

TOWN OF WEBSTER

FOR ALL RETIREES WITHOUT VGTL/VADD COVERAGE PRIOR TO RETIREMENT

GROUP TERM LIFE

EMPLOYER CONTRIBUTION: 0%

AMOUNT OF COVERAGE: You may purchase a flat benefit of \$1,000 without evidence of insurability.

Benefit does not reduce, and terminates when you are no longer eligible.

GROUP TERM LIFE insurance is designed to provide benefits to your designated beneficiary for loss of life.

GROUP TERM LIFE ALSO INCLUDES THE FOLLOWING:

- Accelerated Benefit
- Extended Life Insurance Benefit (Waiver of Premium)
- Travel Assistance

DEPENDENT LIFE

EMPLOYER CONTRIBUTION: 0%

Spouse: You may purchase coverage for your eligible spouse in the amount of \$5,000.

Children: You may purchase coverage for your eligible children between the ages of 6 months and 26 years in the amount of \$1,000. Benefits are reduced to \$500 for children from Live Birth to 6 months.

Benefit does not reduce, and terminates when you are no longer eligible.

Important Note

If you are not actively at work on the date your insurance or any increase in insurance is scheduled to take effect, the coverage or increase in coverage will take effect on the day you return to active work. This benefit summary provides a very brief description of USAble Life's insurance products. This is not an insurance policy and only the actual provisions of an issued policy control. USAble Life's policies set forth the rights and obligations of covered persons and USAble Life. Please be aware that certain participation requirements, limitations, or exclusions may apply, and certain coverage may reduce or terminate due to age or lack of eligibility. If you enroll and are approved for coverage, you will be furnished with a certificate of insurance. Please read your insurance documents carefully.

This benefit summary was generated by USAble Life on 4/7/2021 at 11:56 AM and may not reflect changes recently submitted to USAble Life.



EMPLOYEE BENEFITS SUMMARY | 50019104

TOWN OF WEBSTER

FOR ALL RETIREES WITH VGTL/VADD COVERAGE PRIOR TO RETIREMENT

GROUP TERM LIFE

EMPLOYER CONTRIBUTION: 0%

AMOUNT OF COVERAGE: You may purchase a flat benefit of \$1,000 without evidence of insurability.

Benefit does not reduce, and terminates when you are no longer eligible.

GROUP TERM LIFE insurance is designed to provide benefits to your designated beneficiary for loss of life.

GROUP TERM LIFE ALSO INCLUDES THE FOLLOWING:

- Accelerated Benefit
- Extended Life Insurance Benefit (Waiver of Premium)
- Travel Assistance

DEPENDENT LIFE

EMPLOYER CONTRIBUTION: 0%

Spouse: You may purchase coverage for your eligible spouse in the amount of \$5,000.

Children: You may purchase coverage for your eligible children between the ages of 6 months and 26 years in the amount of \$1,000. Benefits are reduced to \$500 for children from Live Birth to 6 months.

Benefit does not reduce, and terminates when you are no longer eligible.

VOLUNTARY GROUP TERM LIFE

EMPLOYER CONTRIBUTION: 0%

Employee: If you are age 69 or younger, you may purchase coverage in the amount of \$5,000 without evidence of insurability.

Benefit terminates at age 75 when you are no longer eligible or your retirement, whichever occurs first.

VOLUNTARY GROUP TERM LIFE (VGTL) If you need additional term life protection for you and your eligible family members, think about USAble Life's low cost VGTL coverage. You select the benefit amounts to suit your specific situation and premium payments are made through payroll deduction.

VOLUNTARY GROUP TERM LIFE ALSO INCLUDES THE FOLLOWING:

- Accelerated Benefit
- Extended Life Insurance Benefit (Waiver of Premium)

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT

EMPLOYER CONTRIBUTION: 0%

Employee: You may purchase coverage in the amount of \$5,000 without evidence of insurability.

Benefit terminates at age 75 when you are no longer eligible or your retirement, whichever occurs first.

VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT (VAD&D) coverage allows you to purchase benefits to provide protection in the event of an unexpected loss of accidental death or dismemberment. Protection is issued on a 24-hour basis for you and your eligible family members and covers you as the result of a covered accident anywhere in the world.

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT ALSO INCLUDES THE FOLLOWING:

- Seat Belt/Air Bag Benefit
- Coma Benefit
- Exposure & Disappearance Benefit
- Repatriation Benefit
- Special Education Coverage

Important Note

If you are not actively at work on the date your insurance or any increase in insurance is scheduled to take effect, the



EMPLOYEE BENEFITS SUMMARY | 50019104

TOWN OF WEBSTER

FOR ALL FULL TIME ACTIVE EMPLOYEES

GROUP TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT

EMPLOYER CONTRIBUTION: 50%

AMOUNT OF COVERAGE: You may purchase a flat benefit of \$5,000 without evidence of insurability.

Benefit does not reduce, and terminates when you are no longer eligible or your retirement, whichever occurs first.

GROUP TERM LIFE insurance is designed to provide benefits to your designated beneficiary for loss of life.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) is payable, if within 365 days of a covered accident, you suffer loss of life or dismemberment. AD&D provides protection for losses occurring on or off the job.

GROUP TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT ALSO INCLUDES THE FOLLOWING:

- Accelerated Benefit
- Extended Life Insurance Benefit (Waiver of Premium)
- Portability
- Seat Belt/Air Bag Benefit
- Coma Benefit
- Exposure & Disappearance Benefit
- Repatriation Benefit
- Special Education Coverage
- Travel Assistance

DEPENDENT LIFE

EMPLOYER CONTRIBUTION: 0%

Spouse: You may purchase coverage for your eligible spouse in the amount of \$5,000.

Children: You may purchase coverage for your eligible children between the ages of 6 months and 26 years in the amount of \$1,000. Benefits are reduced to \$500 for children from Live Birth to 6 months.

Benefit does not reduce, and terminates when you are no longer eligible or your retirement, whichever occurs first.

VOLUNTARY GROUP TERM LIFE

EMPLOYER CONTRIBUTION: 0%

Employee: If you are age 69 or younger, you may purchase coverage in units of \$10,000 to a maximum of \$100,000 without evidence of insurability. Coverage over these amounts to a maximum of \$350,000 is available with evidence of insurability.

Benefits reduce, based on your age, to 65% at age 70, to 50% at age 75, to 35% at age 80, to 25% at age 85, to 20% at age 90, to 15% at age 95, and terminate when you are no longer eligible or your retirement, whichever occurs first.

Spouse: If you have purchased Voluntary GTL for yourself, you may purchase coverage for your eligible spouse, age 69 or younger, in units of \$5,000 to a maximum of \$30,000 through age 69, and \$0 after reaching age 70 without evidence of insurability. Coverage over these amounts to a maximum of \$50,000 is available with evidence of insurability.

Benefits reduce, based on spouse's age, to 65% at age 70, to 50% at age 75, to 35% at age 80, to 25% at age 85, to 20% at age 90, to 15% at age 95, and terminate when you are no longer eligible or your retirement, whichever occurs first.

Child: If you have purchased Voluntary GTL for yourself, you may purchase coverage for your eligible children between the ages of 6 months and 26 years from \$5,000 to \$10,000 in increments of \$5,000. Benefits reduce to \$1,000 for children from live birth to 6 months.

Benefits terminate when they are no longer eligible, or at the termination of your eligibility, whichever occurs first.

VOLUNTARY GROUP TERM LIFE (VGTL) If you need additional term life protection for you and your eligible family members, think about USAble Life's low cost VGTL coverage. You select the benefit amounts to suit your specific situation and premium payments are made through payroll deduction.

VOLUNTARY GROUP TERM LIFE ALSO INCLUDES THE FOLLOWING:

- Accelerated Benefit
- Portability
- Extended Life Insurance Benefit (Waiver of Premium)

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT**EMPLOYER CONTRIBUTION: 0%**

Employee: You may purchase coverage in units of \$10,000 to a maximum of \$350,000 without evidence of insurability.

Benefits reduce, based on your age, to 65% at age 70, to 50% at age 75, to 35% at age 80, to 25% at age 85, to 20% at age 90, to 15% at age 95, and terminate when you are no longer eligible or your retirement, whichever occurs first.

Spouse: If you have purchased Voluntary AD&D for yourself, you may purchase coverage for your eligible spouse in units of \$10,000 to a maximum of \$50,000 without evidence of insurability.

Benefits reduce, based on spouse's age, to 65% at age 70, to 50% at age 75, to 35% at age 80, to 25% at age 85, to 20% at age 90, to 15% at age 95, and terminate when you are no longer eligible or your retirement, whichever occurs first.

Child: If you have purchased Voluntary AD&D for yourself, you may purchase coverage for your eligible children between the ages of 6 months and 26 years from \$5,000 to \$10,000 in increments of \$5,000. Benefits reduce to \$1,000 for children from live birth to 6 months.

Benefits terminate when they are no longer eligible, or at the termination of your eligibility, whichever occurs first.

VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT (VAD&D) coverage allows you to purchase benefits to provide protection in the event of an unexpected loss of accidental death or dismemberment. Protection is issued on a 24-hour basis for you and your eligible family members and covers you as the result of a covered accident anywhere in the world.

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT ALSO INCLUDES THE FOLLOWING:

- Seat Belt/Air Bag Benefit
- Coma Benefit
- Exposure & Disappearance Benefit
- Repatriation Benefit
- Special Education Coverage

GROUP ACCIDENT RECOVERY (24 HOUR COVERAGE)**EMPLOYER CONTRIBUTION: 0%**

If you are age 69 or younger, you may purchase Accident Recovery benefits, which provide comprehensive coverage for accidental injuries including hospitalization, rehab and physical therapy. Benefits are paid directly to you and there is no coordination of benefits with your medical plan. Coverage is also available for your spouse and children.

HIGHLIGHTS OF THE BASIC PLAN INCLUDE:

- Physician Office Visit: \$125/2 visits
- Initial Hospitalization: \$1000
- Ambulance (Air/Ground): \$1250/\$200
- Physical Therapy: \$100/ 6 visits
- Transportation (for non-local treatment): \$400/5 Trips
- *Wellness Benefit: \$60
- AD&D Rider: \$100,000

HIGHLIGHTS OF THE SELECT PLAN INCLUDE:

- Physician Office Visit: \$150/2 visits
- Initial Hospitalization: \$1200
- Ambulance (Air/Ground): \$1500/\$240
- Physical Therapy: \$140/ 6 visits
- Transportation (for non-local treatment): \$600/5 Trips
- *Wellness Benefit: \$75
- AD&D Rider: \$100,000

HIGHLIGHTS OF THE ULTRA PLAN INCLUDE:

- Physician Office Visit: \$225/2 visits
- Initial Hospitalization: \$1600
- Ambulance (Air/Ground): \$2000/\$320
- Physical Therapy: \$160/ 6 visits
- Transportation (for non-local treatment): \$700/5 Trips
- *Wellness Benefit: \$105
- AD&D Rider: \$100,000

Important Note

If you are not actively at work on the date your insurance or any increase in insurance is scheduled to take effect, the coverage or increase in coverage will take effect on the day you return to active work. This benefit summary provides a very brief description of USAble Life's insurance products. This is not an insurance policy and only the actual provisions of an issued policy control. USAble Life's policies set forth the rights and obligations of covered persons and USAble Life. Please be aware that certain participation requirements, limitations, or exclusions may apply, and certain coverage may reduce or terminate due to age or lack of eligibility. If you enroll and are approved for coverage, you will be furnished with a certificate

Town Of Webster

Voluntary Term Life- Employee's Monthly Cost

Each employee may select any amount desired in units of \$10,000 to a maximum of \$350,000.
Children up to age 26 may be covered in increments of either \$ 5,000 or \$10,000 guaranteed issue

	Age Brackets											
Benefit	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+	AD&D All Ages
\$ 10,000	\$0.70	\$0.70	\$0.90	\$1.30	\$2.10	\$3.90	\$6.20	\$9.50	\$14.90	\$27.70	\$48.10	\$0.30
\$ 20,000	\$1.40	\$1.40	\$1.80	\$2.60	\$4.20	\$7.80	\$12.40	\$19.00	\$29.80	\$55.40	\$96.20	\$0.60
\$ 30,000	\$2.10	\$2.10	\$2.70	\$3.90	\$6.30	\$11.70	\$18.60	\$28.50	\$44.70	\$83.10	\$144.30	\$0.90
\$ 40,000	\$2.80	\$2.80	\$3.60	\$5.20	\$8.40	\$15.60	\$24.80	\$38.00	\$59.60	\$110.80	\$192.40	\$1.20
\$ 50,000	\$3.50	\$3.50	\$4.50	\$6.50	\$10.50	\$19.50	\$31.00	\$47.50	\$74.50	\$138.50	\$240.50	\$1.50
\$ 60,000	\$4.20	\$4.20	\$5.40	\$7.80	\$12.60	\$23.40	\$37.20	\$57.00	\$89.40	\$166.20	\$288.60	\$1.80
\$ 70,000	\$4.90	\$4.90	\$6.30	\$9.10	\$14.70	\$27.30	\$43.40	\$66.50	\$104.30	\$193.90	\$336.70	\$2.10
\$ 80,000	\$5.60	\$5.60	\$7.20	\$10.40	\$16.80	\$31.20	\$49.60	\$76.00	\$119.20	\$221.60	\$384.80	\$2.40
\$ 90,000	\$6.30	\$6.30	\$8.10	\$11.70	\$18.90	\$35.10	\$55.80	\$85.50	\$134.10	\$249.30	\$432.90	\$2.70
\$ 100,000	\$7.00	\$7.00	\$9.00	\$13.00	\$21.00	\$39.00	\$62.00	\$95.00	\$149.00	\$277.00	\$481.00	\$3.00
\$ 110,000	\$7.70	\$7.70	\$9.90	\$14.30	\$23.10	\$42.90	\$68.20	\$104.50	\$163.90	\$304.70	\$529.10	\$3.30
\$ 120,000	\$8.40	\$8.40	\$10.80	\$15.60	\$25.20	\$46.80	\$74.40	\$114.00	\$178.80	\$332.40	\$577.20	\$3.60
\$ 130,000	\$9.10	\$9.10	\$11.70	\$16.90	\$27.30	\$50.70	\$80.60	\$123.50	\$193.70	\$360.10	\$625.30	\$3.90
\$ 140,000	\$9.80	\$9.80	\$12.60	\$18.20	\$29.40	\$54.60	\$86.80	\$133.00	\$208.60	\$387.80	\$673.40	\$4.20
\$ 150,000	\$10.50	\$10.50	\$13.50	\$19.50	\$31.50	\$58.50	\$93.00	\$142.50	\$223.50	\$415.50	\$721.50	\$4.50
\$ 160,000	\$11.20	\$11.20	\$14.40	\$20.80	\$33.60	\$62.40	\$99.20	\$152.00	\$238.40	\$443.20	\$769.60	\$4.80
\$ 170,000	\$11.90	\$11.90	\$15.30	\$22.10	\$35.70	\$66.30	\$105.40	\$161.50	\$253.30	\$470.90	\$817.70	\$5.10
\$ 180,000	\$12.60	\$12.60	\$16.20	\$23.40	\$37.80	\$70.20	\$111.60	\$171.00	\$268.20	\$498.60	\$865.80	\$5.40
\$ 190,000	\$13.30	\$13.30	\$17.10	\$24.70	\$39.90	\$74.10	\$117.80	\$180.50	\$283.10	\$526.30	\$913.90	\$5.70
\$ 200,000	\$14.00	\$14.00	\$18.00	\$26.00	\$42.00	\$78.00	\$124.00	\$190.00	\$298.00	\$554.00	\$962.00	\$6.00
\$ 210,000	\$14.70	\$14.70	\$18.90	\$27.30	\$44.10	\$81.90	\$130.20	\$199.50	\$312.90	\$581.70	\$1,010.10	\$6.30
\$ 220,000	\$15.40	\$15.40	\$19.80	\$28.60	\$46.20	\$85.80	\$136.40	\$209.00	\$327.80	\$609.40	\$1,058.20	\$6.60
\$ 230,000	\$16.10	\$16.10	\$20.70	\$29.90	\$48.30	\$89.70	\$142.60	\$218.50	\$342.70	\$637.10	\$1,106.30	\$6.90
\$ 240,000	\$16.80	\$16.80	\$21.60	\$31.20	\$50.40	\$93.60	\$148.80	\$228.00	\$357.60	\$664.80	\$1,154.40	\$7.20
\$ 250,000	\$17.50	\$17.50	\$22.50	\$32.50	\$52.50	\$97.50	\$155.00	\$237.50	\$372.50	\$692.50	\$1,202.50	\$7.50
\$ 260,000	\$18.20	\$18.20	\$23.40	\$33.80	\$54.60	\$101.40	\$161.20	\$247.00	\$387.40	\$720.20	\$1,250.60	\$7.80
\$ 270,000	\$18.90	\$18.90	\$24.30	\$35.10	\$56.70	\$105.30	\$167.40	\$256.50	\$402.30	\$747.90	\$1,298.70	\$8.10
\$ 280,000	\$19.60	\$19.60	\$25.20	\$36.40	\$58.80	\$109.20	\$173.60	\$266.00	\$417.20	\$775.60	\$1,346.80	\$8.40
\$ 290,000	\$20.30	\$20.30	\$26.10	\$37.70	\$60.90	\$113.10	\$179.80	\$275.50	\$432.10	\$803.30	\$1,394.90	\$8.70
\$ 300,000	\$21.00	\$21.00	\$27.00	\$39.00	\$63.00	\$117.00	\$186.00	\$285.00	\$447.00	\$831.00	\$1,443.00	\$9.00

*Benefits reduce by 35% at age 65, by 50% of original amount at age 70 and terminate at retirement

Children's Benefit	Monthly
\$5,000.00	\$1.50
\$10,000.00	\$3.00



Town Of Webster

Voluntary Term Life- Spousal Monthly Cost

With election of employee benefits, spouse's may select any amount desired in units of \$5,000 to a maximum of \$50,000.

Benefit	Age Brackets											
	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+	AD&D All Ages
\$ 5,000	\$0.35	\$0.35	\$0.45	\$0.65	\$1.05	\$1.95	\$3.10	\$4.75	\$7.45	\$13.85	\$24.05	\$0.15
\$ 10,000	\$0.70	\$0.70	\$0.90	\$1.30	\$2.10	\$3.90	\$6.20	\$9.50	\$14.90	\$27.70	\$48.10	\$0.30
\$ 15,000	\$1.05	\$1.05	\$1.35	\$1.95	\$3.15	\$5.85	\$9.30	\$14.25	\$22.35	\$41.55	\$72.15	\$0.45
\$ 20,000	\$1.40	\$1.40	\$1.80	\$2.60	\$4.20	\$7.80	\$12.40	\$19.00	\$29.80	\$55.40	\$96.20	\$0.60
\$ 25,000	\$1.75	\$1.75	\$2.25	\$3.25	\$5.25	\$9.75	\$15.50	\$23.75	\$37.25	\$69.25	\$120.25	\$0.75
\$ 30,000	\$2.10	\$2.10	\$2.70	\$3.90	\$6.30	\$11.70	\$18.60	\$28.50	\$44.70	\$83.10	\$144.30	\$0.90
\$ 35,000	\$2.45	\$2.45	\$3.15	\$4.55	\$7.35	\$13.65	\$21.70	\$33.25	\$52.15	\$96.95	\$168.35	\$1.05
\$ 40,000	\$2.80	\$2.80	\$3.60	\$5.20	\$8.40	\$15.60	\$24.80	\$38.00	\$59.60	\$110.80	\$192.40	\$1.20
\$ 45,000	\$3.15	\$3.15	\$4.05	\$5.85	\$9.45	\$17.55	\$27.90	\$42.75	\$67.05	\$124.65	\$216.45	\$1.35
\$ 50,000	\$3.50	\$3.50	\$4.50	\$6.50	\$10.50	\$19.50	\$31.00	\$47.50	\$74.50	\$138.50	\$240.50	\$1.50



USABLE Life

P.O. Box 1650 · Little Rock, Arkansas 72203

VOLUNTARY LIFE AND AD&D ENROLLMENT FORM

(PLEASE PRINT)

 New Enrollee Change Decline all coverages

Group #:

Employer: If Evidence of Insurability (EOI) is required, please submit the Evidence of Insurability form along with this enrollment form to us.

Employer's Name

SECTION I. EMPLOYEE INFORMATION

Employee's Legal Name (First, MI, Last)		Social Security No.		
Home Address		City	State	Zip
Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Salary \$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly <input type="checkbox"/> Annual
Occupation (Be Exact)		Dept/Location		
Hours Worked Weekly		Date Employed Full-time		

PLAN INFORMATION - Ask your employer for the details about the cost, if any, and whether you will be required to complete Evidence of Insurability (EOI).

SECTION II. VOLUNTARY COVERAGE(S) - SEE INSTRUCTIONS ON REVERSE OR PAGE 2

Complete this Section if applying for these coverages.
Evidence of Insurability may be required.

	Add New	Delete	Increase Existing	Decrease Existing	Total Amount of Coverage	Premium (Completed by Employer)
--	---------	--------	-------------------	-------------------	--------------------------	---------------------------------

A. Voluntary Group Life:		Employee	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Children	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Voluntary AD&D		Employee	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		(EOI not required)	Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>				
		Children	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you intend to replace existing coverage with this policy? Yes No

Dependents to be covered	Gender	Relationship	Social Security No.	Date of Birth
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			

Have you or your spouse (if applying for coverage) used tobacco products in the past year? **Employee** Yes No
Spouse Yes No

Are you actively at work on the date of this application? Yes No**SECTION III. EMPLOYEE BENEFICIARY DESIGNATION** Check if Change Only

This will revoke any existing beneficiary designations you may have for these benefits.

PRIMARY BENEFICIARY(IES) (Will receive proceeds if living at death of Employee):

Name (Last, First, MI)	Address	SSN	Birthdate	Relationship	Percentage

Total must equal 100% = 0

CONTINGENT BENEFICIARY(IES) (Will receive proceeds if Primary Beneficiary(ies) are not living):

Name (Last, First, MI)	Address	SSN	Birthdate	Relationship	Percentage

Total must equal 100% = 0

I represent that the information provided above is true and correct. I understand that if I am not actively at work on the effective date of my coverage, my insurance will not begin until the day I return to work. For those coverages I have declined, I understand that if I choose to enroll at a later date, Evidence of Insurability may be required. If the Plan provides that any contributions be made by me, I authorize my employer to deduct them from my pay.

Warning: It is or may be a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company or other person. Penalties may include imprisonment, fines, and denial of insurance benefits in accordance with applicable state law.

Date Received - Home Office

Employee's Signature

Date

INSTRUCTIONS – How to Complete Section II

Initial Enrollment –Adding Coverage:

Check "Yes" by each coverage you want. Check "No" by each coverage you do not want.

If you checked "Yes" by a coverage, check the "Add New" box, and complete the "Total Amount of Coverage" for which you are applying.

For Example, you are applying for:

- Voluntary Group Life: \$50,000 on yourself, \$20,000 on your spouse, and no coverage on your children
- Voluntary AD&D: \$100,000 on yourself; \$50,000 on your spouse, \$5,000 on your children

SECTION II. VOLUNTARY COVERAGE(S)

Complete this Section if applying for these coverages.
Evidence of Insurability may be required.

		Add New	Delete	Increase Existing	Decrease Existing	Total Amount of Coverage	Premium (Completed by Employer)
A. Voluntary Group Life:	Employee	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$50,000	
	Spouse	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$20,000	
	Children	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
B. Voluntary AD&D:	Employee	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$100,000	
	(EOI not required) Spouse	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$50,000	
	Children	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$5,000	

How To Change or Delete Coverage:

If you are changing any of your coverage, please complete the information for all of the coverage you have, so that we are sure we have everything correct. Be sure to check the appropriate "Add," "Delete," "Increase", or "Decrease" box.

For Example, you currently have:

- Voluntary Group Life: \$60,000 on yourself, \$30,000 on your spouse, and \$10,000 coverage on your children
- Voluntary AD&D: \$100,000 on yourself only

You want to change your coverage to:

- Voluntary Group Life: \$100,000 on yourself (increase), \$20,000 on spouse (decrease), and no coverage for children (delete)
- Voluntary AD&D: \$100,000 on yourself (no change), \$50,000 on spouse (add)

SECTION II. VOLUNTARY COVERAGE(S)

Complete this Section if applying for these coverages.
Evidence of Insurability may be required.

		Add New	Delete	Increase Existing	Decrease Existing	Total Amount of Coverage	Premium (Completed by Employer)
A. Voluntary Group Life:	Employee	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	\$100,000	
	Spouse	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	\$20,000	
	Children	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		
B. Voluntary AD&D:	Employee	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$100,000	
	(EOI not required) Spouse	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$50,000	
	Children	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

USAble Life

P.O. Box 1650 • Little Rock, Arkansas 72203

EVIDENCE OF INSURABILITY (Please Print)
A completed Enrollment Form must accompany this form.**SECTION 1 – Completed By Employer**

Group Name	Date of Hire	Telephone # (include area code)	Group Number
Amount of Insurance Applying for: Employee Life: \$ <input type="text"/> Dependent Life \$ <input type="text"/> Disability \$ <input type="text"/> Other: <input type="text"/>			Employee's Annual Salary <input type="text"/>
SECTION 2 – Completed by Employee <input type="checkbox"/> Vol. Group Term Life <input type="checkbox"/> Amount over Guarantee Issue <input type="checkbox"/> Late Enrollee			
Name (First, MI, Last) <input type="text"/>		Social Security No. <input type="text"/>	
Home Address <input type="text"/>		City <input type="text"/>	State <input type="text"/> Zip <input type="text"/> County <input type="text"/>
Date of Birth <input type="text"/>	Birth State or Country <input type="text"/>	Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="text"/>	Height (ft-in.) <input type="text"/> Weight (lbs.) <input type="text"/> Work Phone <input type="text"/> Home Phone <input type="text"/>

Spouse & Children Information – Complete if Applying for Dependent's Coverage.

Person Proposed for Insurance Show first, middle, last name <input type="text"/>	Occupation <input type="text"/>	Date of Birth & Place				Height <input type="text"/>	Weight <input type="text"/>	Marital Status <input type="text"/>	Sex <input type="text"/>
		Month <input type="text"/>	Day <input type="text"/>	Year <input type="text"/>	State or Country <input type="text"/>				
(Spouse) <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
(Child) <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
(Child) <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
(Child) <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Spouse's Social Security No.: <input type="text"/>	Spouse's Work Telephone #: <input type="text"/>								

SECTION 3 – Insurability Questionnaire

1. Has anyone to be covered used any tobacco or nicotine products in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Does anyone to be covered have any condition for which consultation or treatment is contemplated or has been advised? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has anyone to be covered been hospitalized for any reason during the past five (5) years? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has anyone to be covered consulted a physician in the past one (1) year for any reason? <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has anyone to be covered ever been diagnosed or treated by a member of the medical profession for: Yes <input type="checkbox"/> No <input type="checkbox"/> a. Cancer, cancer related disease or benign tumor? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> b. Disease of the heart or blood vessels, or had a stroke? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> c. Kidney disease or diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> d. Alcohol or drug abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> e. Lung, asthma, liver or blood disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> f. Emotional, nervous system, eating disorder, or mental health problems? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> g. Ulcer, stomach or digestive disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> h. Arthritis, back, bones or joint disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> i. Bladder, urinary system or reproductive organs disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Has anyone to be covered ever been diagnosed or treated by a member of the medical profession for: Acquired Immunodeficiency Syndrome ("AIDS") or AIDS Related Complex, or Human Immunodeficiency Virus ("HIV")? <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Has anyone to be covered ever been diagnosed or treated by a member of the medical profession for hypertension (high blood pressure) or high cholesterol? If yes, list name of person(s), medications taken, medication dosage, last two blood pressure readings, and/or last two cholesterol readings in Section 4. <input type="checkbox"/> Yes <input type="checkbox"/> No
8. Is anyone to be covered currently taking medication(s)? If yes, list name of person, reasons, medications and dosage in Section 4. <input type="checkbox"/> Yes <input type="checkbox"/> No
9. Has anyone to be covered ever had any impairments, diseases or illnesses not covered in questions 2 – 8? <input type="checkbox"/> Yes <input type="checkbox"/> No
10a. Are you now pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 10b. Have you ever had an ectopic pregnancy, a problem pregnancy, a miscarriage, a problem delivery, a therapeutic abortion, or a Cesarean section? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
11. Are you actively at work on the date of this application and have you been actively at work for the 31 days prior to such date? If No, give full details in Section 4. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
12. Names, addresses, and phone numbers of the personal physicians of all applicants: <input type="text"/>

SECTION 4 – Give Details to "Yes" answers to questions 2 through 10 include dates of treatment: Separate Sheet Attached

Ques. No. & Individual	Illness/Reason for Checkup or Medication & Dosage or Doctor's Treatment/Consultation	Date & Duration	Full Name, Complete Address and Telephone Number of Doctors & Hospitals
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Be Sure to Read the Important Disclosures and sign on Page 2/Reverse

Employee's Name (First, MI, Last)

Social Security #

Employer Name

NOTICE FOR PROPOSED INSURED

IMPORTANT NOTICE FOR DISABILITY COVERAGE

Acceptance of your application for disability income insurance will be based upon the information contained in the Evidence of Insurability, including the medical information disclosed and information obtained from your medical providers. **Your insurance coverage may not be issued as applied for.** If not, an "Exclusion of Coverage Amendment" will be attached to your certificate of coverage.

PLEASE READ YOUR CERTIFICATE OF COVERAGE CAREFULLY UPON ITS RECEIPT.

IMPORTANT NOTICE CONCERNING YOUR EFFECTIVE DATE

1. Insurance will not be effective until the application is approved by USAble Life.
2. Insurance will not be effective if there has been a change in the health of the proposed insured(s) after the date of the application and prior to the effective date.
3. For benefits sheltered under a Section 125 Cafeteria plan: To satisfy premium deduction requirements of your employer and dating requirements of the Section 125 Plan, your coverage will be dated and become effective on the first day of the month following the effective date (anniversary date for resolicitation) of the Section 125 agreement or on the first day of the month following underwriting approval, whichever is later. There is no coverage until the effective date of the policy.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

In signing below, I authorize any hospital, physician, medical practitioner, clinic, pharmacy, pharmacy benefits manager, medically related facility, insurance company, DMV, MIB, Inc., and any consumer reporting agency to release any information regarding me or my past or present health to USAble Life, its reinsurers and legal representatives for the purpose of evaluating this Enrollment Form for insurance. Information subject to this authorization includes facts about my physical and mental health, advice or treatment; prescriptions; hazardous activities, driving record; age; occupation; income; and my use of alcohol, drugs, and tobacco. This information will be used to determine eligibility for insurance. This authorization does not authorize the release of genetic screening or testing results.

I also authorize USAble Life or its reinsurers to disclose all such information to any physician, or any other insurance company in order to evaluate a claim or an application for insurance. I authorize USAble Life, its reinsurers, and its legal representatives to make a brief report of my/our personal health information to MIB, Inc. All sources except MIB, Inc. may give these facts to any insurance support organization authorized by USAble Life to collect and transmit them.

This authorization shall remain valid for a period of two years from the issue date of the coverage. A photocopy of this authorization will be as valid as the original. A copy of the authorization is available to me or my representative upon request to USAble Life.

I understand that this authorization may be revoked at any time. Such revocation must be in writing, and will not be effective until USAble Life and the provider of the information receive it. My revocation will not be effective with respect to disclosures made by a covered entity in reliance on this authorization before it was revoked.

Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules.

If an investigative consumer report is made, I can choose to be interviewed and to receive a copy of the report upon request.

I understand that any insurance will not take effect unless and until USAble Life approves this enrollment request. If the coverage is not issued as requested, I authorize USAble Life to issue reduced benefits and adjust premiums to match the coverage issued. I authorize my employer to deduct the premiums for this insurance from my earnings (unless the coverage for which I am requesting allows for alternate methods to pay insurance premiums).

I acknowledge receipt of written notification describing the use of MIB, Inc. as required by the Fair Credit Reporting Act and the Notice of Insurance Information Practices. I have read and understand this form in its entirety and the notices, authorizations, and certifications contained within.

Insurance Fraud Warning – 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 fines and confinement in prison.

Date Received Home Office

Signed at: _____ Date of Application: _____
City and State _____ Month, Day, Year _____
X _____ X _____
Agent's Signature _____ Applicant's Signature _____



perspectivesltd.com
800.456.6327

EAP

Employee Assistance Program



Confidential And No Cost

We know that confidentiality and costs are important to you.

That's why we offer **CONFIDENTIAL** assistance to employees and their families. And, your personal information is not disclosed to anyone unless you provide written consent or as required by law.

In addition, Perspectives EAP services are provided at **NO COST** to you. Your employer provides Perspectives EAP as a benefit because they value you. If we refer you to an outside resource for additional support, we'll advise you about potential costs and whether they may be covered by your insurance.

Additional Services Just For You!

Your employer has selected enhanced services for you and your family as a part of your Perspectives EAP benefit.

LEGAL AND FINANCIAL SERVICES

At some point in life, we all find ourselves in need of legal or financial advice. Whether we're planning for retirement or college, or facing a divorce or potential legal battle, it's often hard to know where to start.

Perspectives Legal / Financial Services provide you with phone access to specialists who can help you understand your options and point you in the right direction for the help you need. If you do require an attorney, you will be given a referral to our network that includes a **FREE** 30 minute consultation and 25% reduction in attorney fees.

WORKLIFE SERVICES

In addition to WorkLife Online, you have access to the relocation center and **FREE** phone consultations with specialists who assist families with child and eldercare issues, as well as convenience services. Our national network of pre-screened child and eldercare providers offer a time-saving service for you and the people you care about.

Just call 800.456.6327 or log into perspectivesltd.com with your username and password to learn more or get started.

PLEASE TAKE A MINUTE TO LOG INTO YOUR ACCOUNT
TO SEE THE BENEFITS OF PERSPECTIVES EAP.

Username

MEGA

Password

perspectives

We Help With Issues That Impact Life

We can help you resolve stressful personal and family issues, or direct you to legal, financial or child care resources when you need them most.

COMMON ISSUES WE HELP PEOPLE

WITH EVERYDAY INCLUDE:

- + Alcohol and Drug Abuse
- + Attention Deficit Disorder (ADD)
- + Attention Deficit Hyper-activity Disorder (ADHD)
- + Addictions
- + Adoption
- + Anger Issues
- + Anxiety
- + Budgeting
- + Child Care Resources
- + College Planning
- + Communications Issues
- + Coping with Change
- + Depression
- + Divorce
- + Domestic Violence
- + Eating Disorders
- + Effective Communication
- + Elder Care Resources
- + Emotional Issues
- + Family Issues
- + Financial Resources
- + Grief
- + Legal Resources
- + Leisure Travel Time
- + Marital and Couples Counseling
- + Mental Health
- + Parenting
- + Pet Care Resources
- + Post Traumatic Stress Disorder
- + Relationship Issues
- + Stress

We're Available When You Need Us

Perspectives EAP is available 24/7 and can be accessed three ways:

OVER THE PHONE

Masters and Doctorate-level EAP counselors are available 24/7 to answer your questions, provide counseling or assist you with useful appropriate resources. Call 800.456.6327 anytime!

IN PERSON

Counselors will listen to your concerns, assess the situation and help you develop an action plan best suited to your needs. When appropriate, this plan may include further in-person sessions with Perspectives or a referral to another qualified professional. Call 800.456.6327, 8 a.m. - 6 p.m. weekdays to schedule an appointment.

ONLINE

Have you ever spent hours "Googling" for good information about parenting, diet, relationships or hundreds of other issues that impact your life? We do our homework so you don't have to!

Perspectives Online is a special website for everyone with Perspectives EAP. It provides information, resources and tools for a vast number of issues, ranging from parenting and child care to health and wellness, career development, workplace training and more. Just visit perspectivesltd.com and log in with your username and password!

FREE Help. Who Doesn't Like That?

We want you to think of Perspectives as the "Everyday Assistance People." Our Employee Assistance Program (EAP) provides support, counseling and resources for life issues that can take a toll on your emotional well-being or take time away from the things you value most, like work and family. Our services are confidential, no cost to you and available when you need them!



PERSPECTIVES WORK-LIFE PROGRAM

A Selection of "Wrap-around" Work-Life Services Serving EAPs Nationwide.

800.456.6327
perspectivesltd.com
Username: MEGA
Password: perspectives

CHILDCARE	ELDERCARE	CONVENIENCE SERVICES	LEGAL
<p>Childcare Consultation & Referrals:</p> <ul style="list-style-type: none">• Before/After School Care• Childcare Centers• Family Day Care• Nannies & In-home Care• Summer Camps <p>Information & Support:</p> <ul style="list-style-type: none">• Adolescence & Child Development• Adoption• New Parents• Pregnancy• Special Needs	<p>Consultation & Referrals:</p> <ul style="list-style-type: none">• Assisted Living Facilities• Caregiver Support• Community Services• Home Health Care• Hospice Providers• Nursing Homes• Respite Care Providers• Transportation Services	<p>Information & Referrals:</p> <ul style="list-style-type: none">• Community Education Classes• Fitness Programs & Trainers• Home Cleaning• Home Repair Services• Moving Services• Organizer Services• Pet Care• Relocation Information• Yoga Classes	<p>Consultation & Referrals:</p> <ul style="list-style-type: none">• Bankruptcy• Child Custody & Support• Consumer Issues• Elder Law• Estate Planning• Immigration• Landlord Tenant Disputes• Real Estate Concerns• Restraining Orders• Separation & Divorce• Wills & Trusts
NUTRITION	HEALTH	WORK	FINANCIAL
<p>Resources & Referrals:</p> <ul style="list-style-type: none">• Child Friendly Meals• Diabetes• Food Allergies• Gastrointestinal Problems• Healthy Eating• High Blood Pressure• High Cholesterol• Lactation• Weight Management	<p>Resources & Referrals:</p> <ul style="list-style-type: none">• Complementary Medical Providers• Health Coaches• Health Spas• Meditation Programs• Mindfulness Programs• Sleep Programs• Smoking Cessation Programs• Support Groups for Chronic Illness• Twelve Step Programs	<p>Resources & Referrals:</p> <ul style="list-style-type: none">• Career Exploration• Interest Testing• Job Performance Concerns• Job Search Strategies• Resume Review• Volunteer Work	<p>Consultation & Referrals:</p> <ul style="list-style-type: none">• Budgeting• Credit Problems• Debt Management• Financial Wellbeing• Financial Aid• Homebuying Information• Insurance Planning• Retirement Planning• Tax Resources