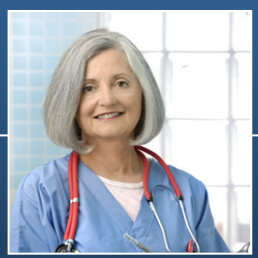
CORNERSTONE
INSURANCE GROUP

2022 Employee Benefits Summary

O'Fallon
District 90
Learning today, leading tomorrow





PLAN YEAR | **1.1.2022 - 12.31.2022**

That’s why at O'Fallon District 90 we are committed to a comprehensive employee benefit program that helps our employees stay healthy, feel secure, and maintain a work/life balance.

Stay Healthy

- Medical Insurance
- Voluntary Dental Insurance
- Voluntary Vision Care

Feeling Secure

- Employer Paid Life Insurance
- Voluntary Life Insurance

Contact Information

Please feel free to contact your dedicated Cornerstone Account Executives –
Ashley Peterson @ 618.391.1046 or ashleyp@cornerstoneinsurancegroup.com
Kari Unterbrink @ 618.391.1028 or kariu@cornerstoneinsurancegroup.com

For enrollment/change inquiries contact **Carrie Bowen**.

MEDICAL:

Blue Cross Blue Shield
800.676.2583
www.bcbsil.com

DENTAL:

Guardian
800.541.7846
www.guardiananytime.com

VISION:

Guardian
800.541.7846
www.guardiananytime.com

EMPLOYER PAID BASIC LIFE / VOLUNTARY LIFE INSURANCE

Guardian
800.541.7846
www.guardiananytime.com

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

Medical Insurance

All eligible employees are offered the opportunity to enroll in O'Fallon District 90's medical plans administered by Blue Cross Blue Shield of IL. Three plans are offered from which you may choose. The plans utilize the excellent local and national Blue Cross Blue Shield networks, in an effort to provide you regional and nationwide access to physicians.

Who is Eligible and When:

- **All eligible employees**
  - Coverage begins the Date of Hire
  - Coverage terms at midnight on date of termination

Medical Insurance Cost per Pay – Effective January 1, 2022

OPTION 1 - HRA PLAN				
HRA	Current 26 pays	**Renewal 26 pays**	Current 20 pays	**Renewal 20 pays**
Employee Only	$0.00	**$0.00**	$0.00	**$0.00**
Employee & Spouse	$224.36	**$226.19**	$291.67	**$294.05**
Employee & Children	$201.65	**$203.02**	$262.14	**$263.93**
Family	$240.27	**$243.14**	$312.35	**$316.08**

OPTION 2 – HIGH DED PLAN				
NO HRA	Current 26 pays	**Renewal 26 pays**	Current 20 pays	**Renewal 20 pays**
Employee Only	$0.00	**$0.00**	$0.00	**$0.00**
Employee & Spouse	$178.25	**$182.27**	$231.72	**$236.95**
Employee & Children	$157.10	**$160.59**	$204.23	**$208.76**
Family	$190.57	**$195.80**	$247.75	**$254.54**

OPTION 3 – HSA PLAN				
H.S.A.	Current 26 pays	**Renewal 26 pays**	Current 20 pays	**Renewal 20 pays**
Employee Only	$0.00	**$0.00**	$0.00	**$0.00**
Employee & Spouse	$59.63	**$60.68**	$77.52	**$78.89**
Employee & Children	$42.52	**$43.14**	$55.28	**$56.09**
Family	$62.75	**$64.78**	$81.57	**$84.21**

If you are enrolled in Option 3 - the District will deposit $62.50 a month into your H.S.A account ($750 a year).

BlueCross BlueShield of Illinois

OFallon CCSD #90: PPO Plan

Option 1 - PPO w/ HRA

Coverage for: Individual/Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-828-3116 or at https://policy-srv.box.com/s/7jqzc7kb9s0k31z7nsfavnoklesn9jsp.

For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible? See Pg 2 for HRA	For In-Network: $3,000 Individual / $6,000 Family For Out-of-Network: $6,000 Individual / $12,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Certain preventive care, services that charge a copay, prescription drugs, and emergency room services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without Cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For In-Network: $5,000 Individual / $10,000 Family For Out-of-Network: $10,000 Individual / $20,000 Family Prescription drug expense limit: $2,000 Individual / $4,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsil.com or call 1-800-828-3116 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit; deductible does not apply	30% coinsurance	No benefits will be provided for services which are not, in the reasonable judgment of Blue Cross and Blue Shield, medically necessary. Virtual Visits: $25/visit; deductible does not apply. See your benefit booklet* for details.
	Specialist visit	$50 copay/visit; deductible does not apply	30% coinsurance	None
	Preventive care/screening/ immunization	No Charge; deductible does not apply	30% coinsurance; deductible does not apply	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	

O'Fallon CCSD #90 Health Reimbursement Arrangement (HRA)

- You are responsible for the first $400 of deductible expenses per covered individual. Your employer will provide reimbursement up to $2,600 per covered individual.
- You are responsible for the first $800 of coinsurance expenses per covered individual. Your employer will provide reimbursement up to $1,200 per covered individual.
- Your maximum out-of-pocket is $1,200 per individual / $2,400 per family.

*For more information about limitations and exceptions, see the plan or policy document at https://policy-srv.box.com/s/7jqzc7kb9s0k31z7nsfavnoklesn9jsp.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsil.com	Generic drugs	$12 copay/prescription (retail) $24 copay/prescription (mail order); deductible does not apply	$12 copay/prescription (retail); deductible does not apply	34-day supply at Retail 90-day supply at Mail Order Rx Out-of-Pocket Expense Limit: $2,000 Individual/$4,000 Family For Out-of-Network drug provider, you are responsible for 25% of the eligible amount after the copayment. Certain women's preventive services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact Customer Service.
	Preferred brand drugs	$30 copay/prescription (retail) $60 copay/prescription (mail order); deductible does not apply	$30 copay/prescription (retail); deductible does not apply	
	Non-preferred brand drugs	$50 copay/prescription (retail) $100 copay/prescription (mail order); deductible does not apply	$50 copay/prescription (retail); deductible does not apply	
	Specialty drugs	$50 copay/prescription (retail); deductible does not apply	$50 copay/prescription (retail); deductible does not apply	Specialty drug coverage based on group policy. Prior authorization may be required. Specialty retail limited to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Preauthorization may be required.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$300 copay/visit; deductible does not apply	$300 copay/visit deductible does not apply	Copay waived if admitted.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Preauthorization may be required for non-emergency transportation; see your benefit booklet* for details.
	Urgent Care	$50 copay/visit; deductible does not apply	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Preauthorization required.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None

*For more information about limitations and exceptions, see the plan or policy document at https://policy-srv.box.com/s/7jqzc7kb9s0k31z7nsfavnoklesn9jsp.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/office visit; deductible does not apply 10% coinsurance for other outpatient services	30% coinsurance	Virtual Visits: $25/visit; deductible does not apply. See your benefit booklet* for details. Preauthorization may be required; see your benefit booklet* for details.
	Inpatient services	10% coinsurance	30% coinsurance	Preauthorization required.
If you are pregnant	Office visits	$25 copay/visit; deductible does not apply	30% coinsurance	Copay applies for the first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and service described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	None
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Preauthorization may be required.
	Rehabilitation services	10% coinsurance	30% coinsurance	Preauthorization may be required.
	Habilitation services	10% coinsurance	30% coinsurance	
	Skilled nursing care	10% coinsurance	30% coinsurance	Preauthorization may be required.
	Durable medical equipment	10% coinsurance	30% coinsurance	Benefits are limited to items used to serve a medical purpose. Durable Medical Equipment benefits are provided for both purchase and rental equipment (up to the purchase price). Preauthorization may be required.
	Hospice services	10% coinsurance	30% coinsurance	Preauthorization may be required.

*For more information about limitations and exceptions, see the plan or policy document at https://policy-srv.box.com/s/7jqzc7kb9s0k31z7nsfavnoklesn9jsp.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Dental care (Adult)
- Infertility treatment
- Long term care
- Routine eye care (Adult)
- Routine foot care (with the exception of person diagnosed with diabetes)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care (Chiropractic and Osteopathic manipulation limited to 25 visits per calendar year)
- Cosmetic surgery (only for correcting congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)
- Hearing aids (for children 1 per ear every 24 months for, adults up to $2500 per ear every 24 months)
- Most coverage outside the United States. See www.bcbsil.com
- Non-emergency when traveling outside the U.S.
- Private-duty nursing (with the exception of inpatient private duty nursing) (Unlimited visits per calendar year)

*For more information about limitations and exceptions, see the plan or policy document at https://policy-srv.box.com/s/7jqzc7kb9s0k31z7nsfavnoklesn9jsp.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-800-828-3116, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross and Blue Shield of Illinois at 1-800-828-3116 or visit www.bcbsil.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at 1-877-527-9431 or visit http://insurance.illinois.gov.

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

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

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-828-3116.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-828-3116.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-828-3116.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-828-3116.

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

TO: **Employees of O'Fallon CCSD #90 covered under the Group Health Insurance PLAN OPTION 1 (HRA)**

FROM: **Cornerstone Insurance Group - Employee Benefits Consultant**

RE: **Medical Insurance & Health Reimbursement Program**

Effective January 1, 2022, Blue Cross Blue Shield of Illinois will continue to be the medical carrier for **O'Fallon CCSD #90**. As a reminder, the Cornerstone Insurance Group will administer the Health Reimbursement Arrangement (HRA). Instructions for reimbursement are below:

Mail or Fax Explanation of Benefits (EOB) with Claim Form to
The Cornerstone Insurance Group, Admin Division
721 Emerson Road, Suite 500
St. Louis, MO 63141
Phone – 314.373.2930 / Fax – 314.373.2931
Email to: admindept@cornerstoneinsurancegroup.com

Secure Consumer Portal: https://cigpart.lh1ondemand.com

If you have not already signed in and are NOT a new enrollee:
You will login as an EXISTING USER for the first time

Username: first letter of your first name + last name + last 4 digits of SSN
Password: last 4 digits of SSN (you can change after initial login)

If you are a NEW enrollee:
Please contact Cornerstone Rep to provide temporary login/pw

You must login from a computer/tablet prior to the mobile application access

If you have questions regarding the new reimbursement procedures or need assistance please contact your Cornerstone Representative:
Ashley Peterson (ashleyp@cornerstoneinsurancegroup.com) 618.391.1046

DEADLINE: Request for Reimbursement is 90 days after the end of the plan year. (March 31st)

CORNERSTONE INSURANCE GROUP

O'Fallon CCSD#90

Section 105 Employer Provided Deductible Reimbursement Plan

Reimbursement Request

Employee's Name:	**Social Security No:**
Mailing Address:_____	**Telephone No. or Email Address:** _____

Instructions:

- Complete the necessary information below for qualifying expenses incurred by you or your eligible dependents for which you request reimbursement.
- Expenses covered by your medical care plan must be submitted under that Plan first, even if it will be applied to the deductible or otherwise unpaid by the medical care plan, and **the resulting EOB must be submitted with your reimbursement request.** *(2021 claims must be submitted by March 31, 2022.)*
- Claims incurred during a Plan Year may be filed up to 90 days after the end of the Plan Year or within 90 days after your termination in this plan.
- You are responsible for the first **$400** of deductible expenses per covered individual. Your employer will provide reimbursement up to **$2,600** per covered individual.
- You are responsible for the first **$800** of coinsurance expenses per covered individual. Your employer will provide reimbursement up to **$1,200** per covered individual.
- Your maximum out-of-pocket is **$1,200** per individual / **$2,400** per family.

EXPENSE DETAIL: **(or you may attach a spreadsheet)**

Date expense incurred	Type of expense	Name and Relationship of Person Incurring Expense	Name of Provider	Amount Requested
			Total Requested	

I certify that the requested amounts are not reimbursable by any form of insurance or other benefit plan, and that I have not, nor will not, deduct these expenses on my personal income tax return. I further certify that I have read and understand the limitations on reimbursements as explained in the Summary Plan Description, and I have determined that the submitted expenses are eligible for reimbursement. I hereby agree to indemnify my Employer for any taxes, interest, or penalties imposed due to the failure of my requested expense reimbursements to qualify as eligible expenses under the Deductible Reimbursement Plan.

Signature _____ Date _____

Mail or Fax to:
The Cornerstone Insurance Group, Admin Division
721 Emerson Road, Suite 500
St. Louis, MO 63141
Phone – 314.373.2930 / Fax – 314.373.2931
admindept@cornerstoneinsurancegroup.com
Secure Consumer Portal: https://cigpart.lh1ondemand.com

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-828-3116 or at https://policy-srv.box.com/s/7jqzc7kb9s0k31z7nsfavnoklesn9jsp.

For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For In-Network: $3,000 Individual / $6,000 Family For Out-of-Network: $6,000 Individual / $12,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Certain preventive care, services that charge a copay, prescription drugs, and emergency room services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without Cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For In-Network: $5,000 Individual / $10,000 Family For Out-of-Network: $10,000 Individual / $20,000 Family Prescription drug expense limit: $2,000 Individual / $4,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsil.com or call 1-800-828-3116 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit; deductible does not apply	30% coinsurance	No benefits will be provided for services which are not, in the reasonable judgment of Blue Cross and Blue Shield, medically necessary. Virtual Visits: $25/visit; deductible does not apply. See your benefit booklet* for details.
	Specialist visit	$50 copay/visit; deductible does not apply	30% coinsurance	None
	Preventive care/screening/ immunization	No Charge; deductible does not apply	30% coinsurance; deductible does not apply	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	

*For more information about limitations and exceptions, see the plan or policy document at https://policy-srv.box.com/s/7jqzc7kb9s0k31z7nsfavnoklesn9jsp.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsil.com	Generic drugs	$12 copay/prescription (retail) $24 copay/prescription (mail order); deductible does not apply	$12 copay/prescription (retail); deductible does not apply	34-day supply at Retail 90-day supply at Mail Order Rx Out-of-Pocket Expense Limit: $2,000 Individual/$4,000 Family For Out-of-Network drug provider, you are responsible for 25% of the eligible amount after the copayment. Certain women's preventive services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact Customer Service.
	Preferred brand drugs	$30 copay/prescription (retail) $60 copay/prescription (mail order); deductible does not apply	$30 copay/prescription (retail); deductible does not apply	
	Non-preferred brand drugs	$50 copay/prescription (retail) $100 copay/prescription (mail order); deductible does not apply	$50 copay/prescription (retail); deductible does not apply	
	Specialty drugs	$50 copay/prescription (retail); deductible does not apply	$50 copay/prescription (retail); deductible does not apply	Specialty drug coverage based on group policy. Prior authorization may be required. Specialty retail limited to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Preauthorization may be required.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$300 copay/visit; deductible does not apply	$300 copay/visit deductible does not apply	Copay waived if admitted.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Preauthorization may be required for non-emergency transportation; see your benefit booklet* for details.
	Urgent Care	$50 copay/visit; deductible does not apply	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Preauthorization required.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None

*For more information about limitations and exceptions, see the plan or policy document at https://policy-srv.box.com/s/7jqzc7kb9s0k31z7nsfavnoklesn9jsp.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/office visit; deductible does not apply 10% coinsurance for other outpatient services	30% coinsurance	Virtual Visits: $25/visit; deductible does not apply. See your benefit booklet* for details. Preauthorization may be required; see your benefit booklet* for details.
	Inpatient services	10% coinsurance	30% coinsurance	Preauthorization required.
If you are pregnant	Office visits	$25 copay/visit; deductible does not apply	30% coinsurance	Copay applies for the first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and service described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	None
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Preauthorization may be required.
	Rehabilitation services	10% coinsurance	30% coinsurance	Preauthorization may be required.
	Habilitation services	10% coinsurance	30% coinsurance	
	Skilled nursing care	10% coinsurance	30% coinsurance	Preauthorization may be required.
	Durable medical equipment	10% coinsurance	30% coinsurance	Benefits are limited to items used to serve a medical purpose. Durable Medical Equipment benefits are provided for both purchase and rental equipment (up to the purchase price). Preauthorization may be required.
	Hospice services	10% coinsurance	30% coinsurance	Preauthorization may be required.

*For more information about limitations and exceptions, see the plan or policy document at https://policy-srv.box.com/s/7jqzc7kb9s0k31z7nsfavnoklesn9jsp.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Dental care (Adult)
- Infertility treatment
- Long term care
- Routine eye care (Adult)
- Routine foot care (with the exception of person diagnosed with diabetes)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care (Chiropractic and Osteopathic manipulation limited to 25 visits per calendar year)
- Cosmetic surgery (only for correcting congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)
- Hearing aids (for children 1 per ear every 24 months for, adults up to $2500 per ear every 24 months)
- Most coverage outside the United States. See www.bcbsil.com
- Non-emergency when traveling outside the U.S.
- Private-duty nursing (with the exception of inpatient private duty nursing) (Unlimited visits per calendar year)

*For more information about limitations and exceptions, see the plan or policy document at https://policy-srv.box.com/s/7jqzc7kb9s0k31z7nsfavnoklesn9jsp.

BlueCross BlueShield of Illinois

OFallon CCSD #90: HSA Plan **Option 3 - H.S.A** **

Coverage for: Individual/Family | Plan Type: HDHP

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-828-3116 or at https://policy-srv.box.com/s/wf49v5rwc3r5kn1zuopw6ym5jskifl22.

For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For In-Network: $2,500 Individual / $5,000 Family For Out-of-Network: $5,000 Individual / $10,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Certain preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without Cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $300 deductible for Out-of-Network hospital admission. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For In-Network: $5,000 Individual / $6,850 Family For Out-of-Network: $10,000 Individual / $20,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsil.com or call 1-800-828-3116 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

If you are enrolled in Option 3 - the District will deposit $62.50 a month into your H.S.A account ($750 a year).

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	No benefits will be provided for services which are not in reasonable judgment of blue Cross and Blue Shield, medically necessary. Virtual Visits: 20% coinsurance/visit; deductible applies. See your benefit booklet* for details.
	Specialist visit	20% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No Charge; deductible does not apply	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsil.com	Generic drugs	20% coinsurance	20% coinsurance	34-day supply at Retail 90-day supply at Mail Order Certain women's preventive services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact Customer Service.
	Preferred brand drugs	20% coinsurance	20% coinsurance	
	Non-preferred brand drugs	20% coinsurance	20% coinsurance	
	Specialty drugs	20% coinsurance	Not Covered	Specialty drug coverage based on group policy. Prior authorization may be required. Specialty retail limited to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization may be required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	Preauthorization may be required for non-emergency transportation; see your benefit booklet* for details.
	Urgent Care	20% coinsurance	40% coinsurance	None

*For more information about limitations and exceptions, see the plan or policy document at https://policy-srv.box.com/s/wf49v5rwc3r5kn1zuopw6ym5jskifl22.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization required. $300 deductible per admission Out-of-Network providers.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Virtual Visits: 20% coinsurance/visit; deductible applies. See your benefit booklet* for details.
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization required. $300 deductible per admission Out-of-Network providers.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance or deductible may apply. Maternity care may include tests and service described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	$300 deductible per admission Out-of-Network providers.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Preauthorization may be required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Preauthorization may be required.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	50% coinsurance	$300 deductible per admission Out-of-Network providers. Preauthorization may be required.
	Durable medical equipment	20% coinsurance	40% coinsurance	Benefits are limited to items used to serve a medical purpose. Durable Medical Equipment benefits are provided for both purchase and rental equipment (up to the purchase price). Preauthorization may be required.
	Hospice services	20% coinsurance	40% coinsurance	$300 deductible per admission Out-of-Network providers. Preauthorization may be required.

*For more information about limitations and exceptions, see the plan or policy document at https://policy-srv.box.com/s/wf49v5rwc3r5kn1zuopw6ym5jskifl22.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Dental care (Adult)
- Infertility treatment
- Long term care
- Routine eye care (Adult)
- Routine foot care (with the exception of person diagnosed with diabetes)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care (Chiropractic and Osteopathic manipulation limited to 30 visits per calendar year)
- Cosmetic surgery (only for correcting congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)
- Hearing aids (for children 1 per ear every 24 months for, adults up to $2500 per ear every 24 months)
- Most coverage outside the United States. See www.bcbsil.com
- Non-emergency when traveling outside the U.S.
- Private-duty nursing (with the exception of inpatient private duty nursing) (Unlimited visits per calendar year)

*For more information about limitations and exceptions, see the plan or policy document at https://policy-srv.box.com/s/wf49v5rwc3r5kn1zuopw6ym5jskifl22.

Basic Life and Voluntary Insurance Plans through Guardian

All eligible employees are offered the opportunity to enroll in O'Fallon District 90's Employer Paid Basic Life/AD&D plan provided by Guardian. The plan provides $10,000 of Basic Term Life coverage for all employees. See the summary that follows for more details.

All full time eligible employees are also offered the opportunity to enroll in O'Fallon District 90's Voluntary Plans through Guardian. The plans include Voluntary Dental, Voluntary Vision and Voluntary Life. The plans and rates are detailed on the following pages.

Who is Eligible and When:

- **All eligible employees**
  - Coverage begins Date of Hire
  - Coverage terms at midnight on date of termination

Dental Insurance Cost per Pay – Effective January 1, 2022

LOW PLAN	Current 26 pays	Renewal 26 pays	Current 20 pays	Renewal 20 pays
Employee Only	$9.84	**$9.84**	$12.79	**$12.79**
Employee +1	$18.06	**$18.06**	$23.48	**$23.48**
Employee + 2 (Family)	$34.23	**$34.23**	$44.50	**$44.50**

HIGH PLAN	Current 26 pays	Renewal 26 pays	Current 20 pays	Renewal 20 pays
Employee Only	$22.11	**$22.11**	$28.75	**$28.75**
Employee +1	$40.59	**$40.59**	$52.77	**$52.77**
Employee + 2 (Family)	$58.97	**$58.97**	$76.66	**$76.66**

Guardian Vision Cost per Pay

VISION	Current 26 pays	Renewal 26 pays	Current 20 pays	Renewal 20 pays
Employee Only	$3.79	**$3.79**	**$4.93**	**$4.93**
Employee +1	$5.76	**$5.76**	**$7.48**	**$7.48**
Employee + 2 (Family)	$10.11	**$10.11**	**$13.14**	**$13.14**

Guardian®

Your dental coverage

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

Your Dental Plan	**Option 1: Low Plan**		**Option 2: High Plan**	
Your Network is	DentalGuard Preferred		DentalGuard Preferred	
Your Monthly premium	**$21.31**		**$47.91**	
You and 1 dependent (Spouse or Child)	$39.14		$87.95	
You, Spouse/Domestic Partner and Child(ren)	$74.16		$127.77	
Calendar year deductible	*In-Network*	*Out-of-Network*	*In-Network*	*Out-of-Network*
Individual	$50	$50	$50	$50
Family limit	3 per family		3 per family	
Waived for	Preventive	Preventive	Preventive	Preventive
Charges covered for you (co-insurance)	*In-Network*	*Out-of-Network*	*In-Network*	*Out-of-Network*
Preventive Care	80%	80%	100%	100%
Basic Care	70%	70%	80%	80%
Major Care	0%	0%	50%	50%
Orthodontia	Not Covered (applies to all levels)		50%	50%
Annual Maximum Benefit	$750	$750	$1500	$1500
Maximum Rollover	No		Yes	
Rollover Threshold			$700	
Rollover Amount			$350	
Rollover In-network Amount			$500	
Rollover Account Limit			$1250	
Lifetime Orthodontia Maximum	Not Applicable		$1000	
Dependent Age Limits(Non-Student/Student)	26/30 ‡		26/30 ‡	

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

Guardian®

Your dental coverage

A Sample of Services Covered by Your Plan:

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

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

Guardian®

Your dental coverage

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits including access to an image of your ID Card. Your on-line account will be set up within 30 days after your plan effective date..

Find A Dentist:

Visit www.GuardianAnytime.com
Click on "Find A Provider"; You will need to know your plan, which can be found on the first page of your dental benefit summary.

EXCLUSIONS AND LIMITATIONS

Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred Network PPO plans: This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury. Deductibles apply. The plan does not pay for: oral hygiene services (except as covered under preventive services), orthodontia (unless expressly provided for), cosmetic or experimental treatments (unless they are expressly provided for), any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment. The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic, and prosthodontic services. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract # GP-1-DG2000 et al.
PPO and or Indemnity Special Limitation: Teeth lost or missing before a covered person becomes insured by this plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by this plan. We won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan. R3-DG2000

Guardian®

Your vision coverage

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

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

Your Vision Plan	**Option 1: VSP**		**Option 2: Davis**	
Your Network is	VSP Choice Network		Davis Vision	
Your Monthly premium	**$ 8.22**		**$ 8.22**	
You and 1 dependent	$ 12.47		$ 12.47	
You, Spouse/Domestic partner and Child(ren)	$ 21.90		$ 21.90	
Copay				
Exams Copay	$ 10		$ 10	
Materials Copay *(waived for elective contact lenses)*	$ 25		$ 25	
Sample of Covered Services	*You pay (after copay if applicable):*		*You pay (after copay if applicable):*	
	In-network	*Out-of-network*	*In-network*	*Out-of-network*
Eye Exams	$0	Amount over $39	$0	Amount over $50
Single Vision Lenses	$0	Amount over $23	$0	Amount over $48
Lined Bifocal Lenses	$0	Amount over $37	$0	Amount over $67
Lined Trifocal Lenses	$0	Amount over $49	$0	Amount over $86
Lenticular Lenses	$0	Amount over $64	$0	Amount over $126
Frames	80% of amount over $130[1]	Amount over $46	80% of amount over $130*[2]	Amount over $48
Contact Lenses *(Elective)*	Amount over $130	Amount over $100	N/A	N/A
Contact Lenses *(Elective and conventional)*	N/A	N/A	85% of amount over $130*	Amount over $105
Contact Lenses *(Planned replacement and disposable)*	N/A	N/A	85% of amount over $130*	Amount over $105
Contact Lenses *(Medically Necessary)*	$0	Amount over $210	$0	Amount over $210
Contact Lenses *(Evaluation and fitting)*	15% off UCR	No discounts	No discounts	No discounts
Cosmetic Extras	Avg. 20-25% off retail price	No discounts	Avg. 40-60% off retail price	No discounts
Glasses *(Additional pair of frames and lenses)*	20% off retail price**	No discounts	Courtesy discount from most providers	No discounts
Laser Correction Surgery Discount	Up to 15% off the usual charge or 5% off promotional price	No discounts	Up to 25% off the usual charge or 5% off promotional price	No discounts
Service Frequencies				
Exams	Every calendar year		Every calendar year	
Lenses *(for glasses or contact lenses)*‡‡	Every calendar year		Every calendar year	
Frames	Every two calendar years‡‡‡		Every two calendar years	

Your vision coverage

Your Vision Plan	Option 1: VSP	Option 2: Davis
Network discounts *(glasses and contact lens professional service)*	Limitless within 12 months of exam.	Applies to first purchase & courtesy discount from most providers on subsequent purchases.
Dependent Age Limits (Non-Student/ Student)	26/30	26/30
	Visit www.GuardianAnytime.com and click on "Find a Provider"	

VSP

- ‡‡Benefit includes coverage for glasses or contact lenses, not both.
- Family coverage for spouse and children. The limiting age for unmarried dependents is extended to age 30 if the dependent is a resident of Illinois and has received a release or discharge, other than dishonorable discharge, from military service.
- ** For the discount to apply your purchase must be made within 12 months of the eye exam.
- Charges for an initial purchase can be used toward the material allowance. Any unused balance remaining after the initial purchase cannot be banked for future use. The only exception would be if a member purchases contact lenses from an out of network provider, members can use the balance towards additional contact lenses within the same benefit period.
- [1]Extra $20 on select brands
- Members can use their in network benefits on line at Eyeconic.com.
- *‡‡‡.The VSP system considers contact lenses to be the equivalent of a full pair of eyeglasses (lenses and frames) so while the member can obtain contact lenses one year and standard eyeglass lenses the next year, the frames benefit would not be available until 24 months or two calendar years, depending on the plan design, after the date the member obtained the contact lenses.*

Davis

- ‡‡Benefit includes coverage for glasses or contact lenses, not both.
- Family coverage for spouse and children. The limiting age for unmarried dependents is extended to age 30 if the dependent is a resident of Illinois and has received a release or discharge, other than dishonorable discharge, from military service.
- Contact lenses from Davis Vision's Collection are available at most private practice locations with Full Feature and Materials Only plans. Contacts from the collection are covered in full including fitting and evaluation, in excess of the plan's materials copay. Elective contacts that are not part of the Collection are covered up to the plan's elective contact lens allowance and the materials copay is waived.
- *Additional discounts are not available at all private practice locations. Costco, Walmart, Sam's Club, glasses.com, and 1800contacts.com do not allow additional discounts.
- For Davis Vision, complete eyeglasses must be purchased at one time from one provider. For example, if a member purchases only lenses, he or she cannot purchase frames later in the same benefit period. The member is not eligible for new vision materials until the next benefit period. Only charges for an initial purchase can be used toward the material allowance. Any unused balance remaining after the initial purchase cannot be banked for future use.
- [2]Extra $50 at Visionworks stores and at Visionworks.com.
- Davis Vision offers 2,000 College Tuition Benefit Rewards, which are administered by SAGE CTB, LLC.

Your vision coverage

EXCLUSIONS AND LIMITATIONS

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

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

Laser Correction Surgery:

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

Guardian

Your life coverage

	BASIC LIFE	VOLUNTARY TERM LIFE
Employee Benefit	Your employer provides $10,000 Basic Term Life coverage for all full time employees.	Choice of 6 employer-specified amounts, from $10,000 to $150,000. See Cost Illustration page for details.
Accidental Death and Dismemberment	Your Basic Life coverage includes Accidental Death and Dismemberment coverage.	Employee, Spouse & Child(ren) coverage. Maximum 1 times life amount.
Spouse/Domestic Partner Benefit	N/A	$5,000 increments to a maximum of $75,000. See Cost Illustration page for details.‡
Child Benefit	N/A	Your dependent children age 14 days to 23 years (25 if full time student). You may elect one of the following benefit options: $5,000, $10,000. Subject to state limits. See Cost Illustration page for details.
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when you sign up for coverage during the initial enrollment period.	Guarantee Issue coverage up to $10,000 per employee	We Guarantee Issue coverage up to: Employee Less than age 65 $150,000, 65-69 $10,000, $0. Spouse Less than age 65 $50,000, 65-69 $5,000, $0. Dependent children $10,000.
Premiums	Covered by your company if you meet eligibility requirements	Increase on plan anniversary after you enter next five-year age group

Guardian®

Your life coverage

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

Subject to coverage limits

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

Voluntary Life Cost Illustration:

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

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

Policy Election Amount	Policy Election Cost Per Age Bracket								
Employee	**< 30**	**30–34**	**35–39**	**40–44**	**45–49**	**50–54**	**55–59**	**60–64**	**65–69†**
$10,000	$.95	$1.05	$1.35	$1.95	$3.05	$4.95	$7.95	$9.85	$16.85
$25,000	$2.38	$2.63	$3.38	$4.88	$7.63	$12.38	$19.88	$24.63	$42.13
$50,000	$4.75	$5.25	$6.75	$9.75	$15.25	$24.75	$39.75	$49.25	$84.25
$75,000	$7.13	$7.88	$10.13	$14.63	$22.88	$37.13	$59.63	$73.88	$126.38
$100,000	$9.50	$10.50	$13.50	$19.50	$30.50	$49.50	$79.50	$98.50	$168.50
$150,000	$14.25	$15.75	$20.25	$29.25	$45.75	$74.25	$119.25	$147.75	$252.75
Policy Election Amount									
Spouse/DP									
$5,000	$.48	$.53	$.68	$.98	$1.53	$2.48	$3.98	$4.93	$8.43
$10,000	$.95	$1.05	$1.35	$1.95	$3.05	$4.95	$7.95	$9.85	$16.85
$15,000	$1.43	$1.58	$2.03	$2.93	$4.58	$7.43	$11.93	$14.78	$25.28
$20,000	$1.90	$2.10	$2.70	$3.90	$6.10	$9.90	$15.90	$19.70	$33.70
$25,000	$2.38	$2.63	$3.38	$4.88	$7.63	$12.38	$19.88	$24.63	$42.13
$30,000	$2.85	$3.15	$4.05	$5.85	$9.15	$14.85	$23.85	$29.55	$50.55
$35,000	$3.33	$3.68	$4.73	$6.83	$10.68	$17.33	$27.83	$34.48	$58.98
$40,000	$3.80	$4.20	$5.40	$7.80	$12.20	$19.80	$31.80	$39.40	$67.40
$45,000	$4.28	$4.73	$6.08	$8.78	$13.73	$22.28	$35.78	$44.33	$75.83
$50,000	$4.75	$5.25	$6.75	$9.75	$15.25	$24.75	$39.75	$49.25	$84.25
$55,000	$5.23	$5.78	$7.43	$10.73	$16.78	$27.23	$43.73	$54.18	$92.68
$60,000	$5.70	$6.30	$8.10	$11.70	$18.30	$29.70	$47.70	$59.10	$101.10
$65,000	$6.18	$6.83	$8.78	$12.68	$19.83	$32.18	$51.68	$64.03	$109.53
$70,000	$6.65	$7.35	$9.45	$13.65	$21.35	$34.65	$55.65	$68.95	$117.95
$75,000	$7.13	$7.88	$10.13	$14.63	$22.88	$37.13	$59.63	$73.88	$126.38
Policy Election Amount									
Child(ren)									
$5,000	$0.47	$0.47	$0.47	$0.47	$0.47	$0.47	$0.47	$0.47	$0.47
$10,000	$0.94	$0.94	$0.94	$0.94	$0.94	$0.94	$0.94	$0.94	$0.94

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

LIMITATIONS AND EXCLUSIONS:

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

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

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

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

Voluntary Life Only:

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

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

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

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

WillPrep

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

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

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

How it can help

Access simple documents including wills and power of attorney letters

Speak with consultants to discuss estate planning

Prepare your will with the assistance or support of an attorney

How to access

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

Visit
ibhwillprep.com

User ID
WillPrep

Password
GLIC09

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

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

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

2020-104979 (07/22)

Guardian® • IBH Integrated Behavioral Health

WorkLifeMatters
Help for What Matters Most

Your Employee Assistance Program

WorkLifeMatters Employee Assistance Program offers services to help promote well-being and enhance the quality of life for you and your family.

Support and guidance is available for assistance with family and personal issues online at ibhworklife.com and by phone at 1-800-386-7055.

Help with Health	Help with Family	Help with Legal & Financial
• Healthy living	• Parenting support	• Legal issues
• Stress management	• Child and elder care	• Will preparation
• Mental health	• Learning programs	• Taxes
• Diet and fitness	• Special needs help	• Debt
• Overall wellness		• Financial planning tools and assistance

Connect to a counselor for free support services:

Email: eapcounselor@ibhcorp.com

Phone: 1-800-386-7055

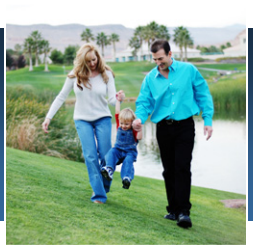
Available 24 hours a day, 7 days a week*

Web: ibhworklife.com

(User name: Matters Password: wlm70101)

*Office hours: Monday-Friday 6am-5pm PST. Live answer exchange available after hours. WorkLifeMatters Program services are provided by Integrated Behavioral Health, Inc., and its contractors. Guardian does not provide any part of WorkLifeMatters program services Guardian is not responsible or liable for care or advice given by any provider or resource under the program. This information is for illustrative purposes only. It is not a contract. Only the Administration Agreement can provide the actual terms, services, limitations and exclusions. Guardian and IBH reserve the right to discontinue the WorkLifeMatters program at any time without notice. Legal services provided through WorkLifeMatters will not be provided in connection with or preparation for any action against Guardian, IBH or your employer. WorkLifeMatters Program services is not an insurance benefit and may not be available in all states. The Guardian Life Insurance Company of America, New York, NY. Integrated Behavioral Health Laguna Niguel, CA. File #2018-56600 Exp. 3/20 PUB 3755

Enrollment Forms



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

Eligibility

If you are a new hire, you will become eligible for coverage on the 1st of the month following 30 days of full time employment. This will be the date on which your coverage becomes available. You may complete your enrollment forms/applications any time before this date, but you must complete the forms within 31 days of the effective date. If you do not submit your enrollment forms within the timeframe above, you must wait until the next annual open enrollment to make your benefit elections.

Who can be added to your plan:

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

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

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

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

CORNERSTONE INSURANCE GROUP

www.cornerstoneinsurancegroup.com

314.373.2900

O'Fallon District 90
Learning today, leading tomorrow

Waiver of Group Health Benefits – 2022

Employee Name (PRINT)

I acknowledge I was offered an employer sponsored group health plan that meets the Affordable Care Act's affordability and minimum value requirements but I choose not to participate in the medical plan.

For the plan year effective ***January 1, 2022 – December 31, 2022***, I am waiving MEDICAL coverage for:

☐ Myself

☐ Spouse/Domestic Partner

☐ Dependents(s):

I am waiving coverage due to:

☐ My preference not to have coverage

☐ Coverage under my spouse's/domestic partner's plan

☐ Other coverage

This other coverage is:

☐ Employer-sponsored Group Plan ☐ Individual policy ☐Medicare ☐ COBRA ☐TRICARE ☐ Medicaid

☐ Other _____

Special Enrollment Notice and Certification – *Please review and sign below if you wish to waive coverage*

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I am declining enrollment as indicated above. I understand that, if I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage, I may be able to enroll myself and my eligible dependents in this plan if I lose, or my eligible dependents lose, eligibility for that other coverage (or if the employer stops contributing towards my or my eligible dependents' other coverage).

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends (or after the employer stops contributing toward the other coverage). If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period.

In addition, I understand that if I have a newly eligible dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I acknowledge I was offered an employer sponsored group health plan that meets the Affordable Care Act's affordability and minimum value requirements but I choose not to participate in the medical plan.

I understand that in order to request special enrollment or obtain more information, I should contact my group administrator.

Employee Signature **Date**

_____

O'Fallon CCSD#90
Benefits Election Form – Medical Enrollment 2022
Effective January 1, 2022

Please make your coverage selections below, and sign and return this form to District Office by **December 11th**

If you do not wish to participate in a plan, please check the box marked "waive," sign and return the form.

Employee Name (please print)

I choose the following medical insurance coverage:

Medical Insurance 26 pays	***Medical Insurance 20 pays***
Plan Option 1 –HRA Plan *(26 pays)* ☐ Employee only - $0.00 ☐ Employee & Spouse - $226.19 ☐ Employee & Child(ren) - $203.02 ☐ Family - $243.14	**Plan Option 1 –HRA Plan *(20 pays)*** ☐ Employee only - $0.00 ☐ Employee & Spouse - $294.05 ☐ Employee & Child(ren) - $263.93 ☐ Family - $316.08
Plan Option 2 – *(26 pays)* **High Deductible Plan – NO HRA** ☐ Employee only - $0.00 ☐ Employee & Spouse - $182.27 ☐ Employee & Child(ren) - $160.59 ☐ Family - $195.80	**Plan Option 2 – *(20 pays)*** **High Deductible Plan – NO HRA** ☐ Employee only - $0.00 ☐ Employee & Spouse - $236.95 ☐ Employee & Child(ren) - $208.76 ☐ Family - $254.54
Plan Option 3 – H.S.A *(26 pays)* ☐ Employee only - $0.00 ☐ Employee & Spouse - $60.68 ☐ Employee & Child(ren) - $43.14 ☐ Family - $64.78	**Plan Option 3 – H.S.A *(20 pays)*** ☐ Employee only - $0.00 ☐ Employee & Spouse - $78.89 ☐ Employee & Child(ren) - $56.09 ☐ Family - $84.21

Waive – NO COVERAGE - Please complete back side for WAIVER of Coverage

IMPORTANT→ If you are a new enrollment or adding dependents you will need to complete a BCBS change form in addition to this election form to provide your personal enrollment information. Please contact Cornerstone Insurance Group.

I understand the coverage I have elected is effective January 1, 2022.

Signature Date

BlueCross BlueShield of Illinois

O'Fallon CCSD#90
P40148 (PPO) P76927 (H.S.A.)

Dearborn National®

APPLICATION AND POLICY CHANGE

PLEASE PRINT — USE BLACK OR BLUE BALLPOINT PEN ONLY — PRESS HARD.

① **ENROLLEE:**	New Enrollment: ☐ Timely ☐ Special ☐ Late	Open Enrollment: ☐ New Member ☐ Plan Change ☐ Add Dependents

② **EFFECTIVE DATE OF BENEFITS:** ___/___/___	Group Number: *P40148 (PPO)* *P76927 (H.S.A.)*	Section Number:	Identification Number:

③ **COBRA / ILLINOIS CONTINUATION SECTION**	Employee Status: ☐ Active Employee ☐ COBRA Continuation ☐ IL Continuation ☐ Retiree, retirement date___/___/___

☐ COBRA: Start Date ___/___/___ Projected End Date ___/___/___	☐ IL Continuation Privilege: Start Date ___/___/___ Projected End Date ___/___/___

Previously covered with group as:

☐ 1. Employee (termination of employment, reduction in hours, other.)
☐ 2. Spouse (divorce from employee, death of employee, other.)
☐ 3. Dependent (reach age limit, other.)
☐ 4. Spouse and Dependents (divorce from employee, death of employee, other.)

④ **COVERAGE APPLIED FOR: Check all that apply.****

After checking coverage applied for or making changes to existing membership, complete Group Number, Section Number, Social Security Number and Name.

Medical - Please check one

☐ Option 1 - HRA Plan P40148 ☐ Option 2 - High Deductible Plan P40148 ☐ Option 3 - H.S.A. Plan P76927

⑤ **CHANGES TO EXISTING MEMBERSHIP: Check all that apply.**

CHANGES	ADD DEPENDENTS	CANCEL DEPENDENTS	CANCEL (Check all that apply)
Date ___/___/___	Date ___/___/___	Date ___/___/___	Date ___/___/___
☐ Name	☐ Marriage	☐ Divorce	☐ Terminate Coverage
☐ Address	☐ Newborn	☐ Age Limit	☐ Waive Coverage**
☐ Telephone	☐ Adoption/Placement	☐ Other:	☐ Leave/Layoff
☐ Reinstate	☐ Legal Guardianship	_____	☐ Out of Service Area Move
☐ From PPO to HSA	☐ Other: _____		☐ Other: _____
			_____
			_____
			_____
			_____
			_____

NOTE:
Only list dependents to be added or dropped in the Family Coverage Information Section U.

*After checking the appropriate physician change, circle reason:

☐ PCP
☐ WPHCP

A. Availability
C. Location
E. Dissatisfied with PCP
G. Staff
B. PCP moved office
D. PCP added to Network
F. PCP office/facility undesirable
H. Other _____

**If not electing coverage, please read, complete and sign Section ⑪.

20005.1114

⑥ **EMPLOYEE INFORMATION:**	Company Name: *O'Fallon District 90*	
Last Name:	First Name:	Mid. Initial
E-Mail Address:	Cell Phone Number:	
Street Address:	Apt. No.:	
City:	State:	Zip:

Date of Birth: ___/___/___ Are You Eligible for Family Coverage: ☐ No ☐ Yes

Health Coverage Elected: ☐ Individual/Employee ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family

Gender: ☐ Male ☐ Female

Employee Social Security Number: _____ — _____ — _____

Employee Identification Number (if known): _____

Telephone No.: Bus.: (_____) _____ Home: (_____) _____ Date of Hire: ___/___/___

Dept. No.: _____ Payroll Location: _____ Employee Clock No.: _____

Employment Status: ☐ Actively at Work ☐ Retired If retired, retirement date:_____ ☐ COBRA/IL Continuation

Are you covered under your employer's health care plan and also covered by Medicare? ☐ No ☐ Yes

If Yes, the section below must be completed:

HIC #: _____	MEDICARE B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: ___/___/___	Start Date: ___/___/___	Start Date: ___/___/___
Start Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___

⑦ **FAMILY COVERAGE INFORMATION:**	List All Eligible Dependents.

⑦Ⓐ ☐ Spouse ☐ Domestic Partner ☐ Party to a Civil Union ☐ Male ☐ Female Date of Birth: ___/___/___

Last Name (Only If Different): _____

First Name: _____ Social Security Number: _____ — _____ — _____

Is this dependent covered under your employer's health care plan and also covered by Medicare? ☐ No ☐ Yes

If Yes, the section below must be completed:

HIC #: _____	MEDICARE B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: ___/___/___	Start Date: ___/___/___	Start Date: ___/___/___
Start Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___

⑥ **EMPLOYEE AND DEPENDENT INFORMATION:**	Company Name: *O'Fallon CCSD #90*		Group #: *P40148 / P76927*
Employee Last Name:	Employee First Name:		Mid. Initial
⑦ **FAMILY COVERAGE INFORMATION:**	List All Eligible Dependents.		

⑦Ⓑ ☐ SON ☐ DAUGHTER Date of Birth: ___/___/___

Last Name (Only If Different): ______________________ First Name: ________________ ☐ ELIGIBLE MILITARY PERSONNEL

Address (if different from Employee's address): ____

Social Security Number: _____ — _____ — ________

Is this dependent covered under your employer's health care plan and also covered by Medicare? ☐ No ☐ Yes

If Yes, the section below must be completed:

HIC #: ______________	MEDICARE B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: ___/___/___	Start Date: ___/___/___	Start Date: ___/___/___
Start Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___

☐ SON ☐ DAUGHTER Date of Birth: ___/___/___

Last Name (Only If Different): ______________________ First Name: ________________ ☐ ELIGIBLE MILITARY PERSONNEL

Address (if different from Employee's address): ____

Social Security Number: _____ — _____ — ________

Is this dependent covered under your employer's health care plan and also covered by Medicare? ☐ No ☐ Yes

If Yes, the section below must be completed:

HIC #: ______________	MEDICARE B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: ___/___/___	Start Date: ___/___/___	Start Date: ___/___/___
Start Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___

☐ SON ☐ DAUGHTER Date of Birth: ___/___/___

Last Name (Only If Different): ______________________ First Name: ________________ ☐ ELIGIBLE MILITARY PERSONNEL

Address (if different from Employee's address): ____

Social Security Number: _____ — _____ — ________

Is this dependent covered under your employer's health care plan and also covered by Medicare? ☐ No ☐ Yes

If Yes, the section below must be completed:

HIC #: ______________	MEDICARE B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: ___/___/___	Start Date: ___/___/___	Start Date: ___/___/___
Start Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___

⑧ **OTHER INSURANCE INFORMATION:**

If you or any of your family members have OTHER GROUP COVERAGE, Check all that apply.

☐ Health: Policy #: _____

☐ Prescription Drug Coverage: Policy #: _____

If Yes: Is the other insurance: ☐ Single Coverage ☐ Family Coverage

EMPLOYED BY: _____ Insured's Name: _____

Date of Birth: ___/___/___

Insurance Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Telephone Number: _____

⑩ **I APPLY FOR COVERAGE AS INDICATED ABOVE**, for which I am or may become eligible under the agreement with Health Care Service Corporation (providing hospital and medical, dental coverage and health maintenance coverage), and/or Dearborn National (providing the life and disability insurance) (the Company). I have read the above statements and represent they are true and complete to the best of my knowledge. I authorize my employer/group to deduct from my pay and remit any required contribution for the cost of said coverage. This authorization is to remain in effect until the Company is notified by me in writing to the contrary.

I understand that the benefits listed in the Certificate(s) will be available subject to the Terms and Conditions thereof effective as listed in the Certificate(s) of Coverage.

Date Signed: ___/___/___ Signature of Applicant: _____

⑪ If you are declining enrollment for yourself or your dependents (including your spouse) because of 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 31 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 31 days after the marriage, birth, adoption, or placement for adoption.

I DO NOT WISH TO ENROLL at this time and understand that the opportunity to enroll at any future time will be subject to such arrangements as may be made with the Company.

Not enrolling for: ☐ Myself ☐ My spouse ☐ My spouse and dependents ☐ My dependents ☐ Myself, my spouse and my dependents

Reason: ☐ Covered under spouse's employer-based health insurance plan (complete "Other Insurance Information" in ⑧)

☐ Covered under a Medicare supplement plan ☐ Other (please explain)_____

Date Signed: ___/___/___ Signature of Applicant: _____

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

Please print clearly and mark carefully.

Employer Name: O'FALLON COMMUNITY CONSOIDATED SCHOOL DISTRICT 90	Group Plan Number: 00483112	Benefits Effective:_____

PLEASE CHECK APPROPRIATE BOX Initial Enrollment Re-Enrollment Add Employee/Dependents Drop/Refuse Coverage Information Change
Increase Amount Family Status Change

Class: ALL ELIGIBLE EMPLOYEES EXCLUDING RETIREE'S Division:_____ Subtotal Code:_____ (Please obtain this from your Employer)

About You:

First, MI, Last Name:

Social Security Number
___ ___ ___ - ___ ___ - ___ ___ ___ ___

Address	City	State	Zip

Gender: M F Date of Birth (mm-dd-yy): ____ - ____ - ____ Phone: ( ) -

Email Address:

Are you married or do you have a spouse? Yes No Date of marriage/union:____-____-_____
Do you have children or other dependents? Yes No Placement date of adopted child: ____-____-_____

About Your Job: Job Title:

Work Status: Active Retired Cobra/State Continuation Hours worked per week: _____	Date of full time hire: _____ - _____ - _____	Annual Salary: $_____

About Your Family: Please include the names of the dependents you wish to enroll for coverage. A dependent is a person that you, as a taxpayer, claim; who relies on you for financial support; and for whom you qualify for a dependent tax exemption. Dependent tax exemptions are subject to IRS rules and regulations. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.

Spouse (First, MI, Last Name) Address/City/State/Zip: Phone: ( ) -		Gender M F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Child/Dependent 1: Address/City/State/Zip: Phone: ( ) -	Add Drop	Gender M F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) Student (post high school) Disabled Non standard dependent
Child/Dependent 2: Address/City/State/Zip: Phone: ( ) -	Add Drop	Gender M F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) Student (post high school) Disabled Non standard dependent

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER
DATE FORM PUBLISHED: Jan 09, 2021

Child/Dependent 3: Address/City/State/Zip: Phone: ( ) -	Add Drop	Gender M F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) Student (post high school) Disabled Non standard dependent
Child/Dependent 4: Address/City/State/Zip: Phone: ( ) -	Add Drop	Gender M F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) Student (post high school) Disabled Non standard dependent

Drop Coverage:

Drop Employee Drop Dependents

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

Last Day of Coverage: _____-_____-_____

Termination of Employment Retirement

Last Day Worked: _____-_____-_____

Other Event: _____

Date of Event: _____-_____-_____

Coverage Being Dropped:

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

Loss Of Other Coverage:

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

Termination of Employment: _____-_____-_____

Divorce/Separation _____-_____-_____

Death of Spouse _____-_____-_____

Termination/Expiration of Coverage _____-_____-_____

Coverage Lost Dental Vision

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

Covered under another insurance plan

Other _____

(additional information may be required)

Dental Coverage:

You must be enrolled to cover your dependents. Check only one box.

Your Monthly Premium	Employee Only	Employee and 1 Dependent	EE, Spouse & Dependent/Child(ren)
Option 1: Low Plan	$21.31	$39.14	$74.16
Option 2: High Plan	$47.91	$87.95	$127.77

I do not want this coverage. If you do not want this Dental Coverage, please mark all that apply:

I am covered under another Dental plan

My spouse is covered under another Dental plan

My dependents are covered under another Dental plan

Vision Coverage:

You must be enrolled to cover your dependents. Check only one box.

Your Monthly Premium	Employee Only	Employee and 1 Dependent	EE, Spouse & Dependent/Child(ren)
Option 1: VSP	$8.22	$12.47	$21.90
Option 2: Davis	$8.22	$12.47	$21.90

I do not want this coverage. If you do not want this Vision Coverage, please mark all that apply:

I am covered under another Vision plan

My spouse is covered under another Vision plan

My dependents are covered under another Vision plan

Guardian Group Plan Number: 00483112 Please print employee name:

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

Benefit reductions apply. Please see plan administrator.

Policy Amount
Employee Only
☑ $10,000
The Guarantee Issue Amount is $10,000.

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

Primary Beneficiaries:

Name:_____ Social Security Number:___-___-____ %___

Date of Birth (mm-dd-yy):___-___-___Address/City/State/Zip:_____

Phone: ( ) - Relationship to Employee:_____

Name:_____ Social Security Number:___-___-____ %___

Date of Birth (mm-dd-yy):___-___-___Address/City/State/Zip:_____

Phone: ( ) - Relationship to Employee:_____

Contingent Beneficiary:_____ Social Security Number: ___-___-____

Date of Birth (mm-dd-yy):___-___-___Address/City/State/Zip:_____

Phone: ( ) - Relationship to Employee:_____

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

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

Important Notes:

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

Voluntary Term Life Coverage With Accidental Death and Dismemberment (AD&D):

You must be enrolled to cover your dependents.

Benefit reductions apply. Please see plan administrator.

Employee

Policy Amount *Check one box only*

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

Guarantee Issue up to: Employee Less than age 65 $150,000*, 65-69 $10,000, $0.

I do not want this coverage

Add Voluntary Life for Spouse

Policy Amount

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

Guarantee Issue up to: Spouse Less than age 65 $50,000*, 65-69 $5,000, $0.

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

I do not want this coverage

Add Voluntary Life for Dependent/Child(ren)

Policy Amount

$5,000 $10,000*

**Guarantee Issue Amount*

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

I do not want this coverage

Important Notes:

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

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

LIFE INSURANCE *continued*

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

Primary Beneficiaries:

Name:_____ Social Security Number:___ ___ ___-___ ___-___ ___ ___ ___ %_____

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

Phone: ( ) - Relationship to Employee:_____

Name:_____ Social Security Number:___ ___ ___-___ ___-___ ___ ___ ___ %_____

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

Phone: ( ) - Relationship to Employee:_____

Contingent Beneficiary:_____ Social Security Number: ___ ___ ___-___ ___-___ ___ ___ ___

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

Phone: ( ) - Relationship to Employee:_____

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

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

Signature

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

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

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

I understand that the premium amounts shown above are estimations and are for illustrative purposes only.

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

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

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

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

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

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

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

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

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

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

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

The laws of New York require the following statement appear: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Does not apply to Life Insurance.)

SIGNATURE OF EMPLOYEE X _____ DATE _____

Enrollment Kit 00483112, 0001, EN

Fraud Warning Statements

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

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

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

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

Connecticut, Iowa, Nebraska, and Oregon: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a fraudulent insurance act, which may be a crime, and may also be subject to civil penalties.

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

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

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

Kansas: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud as determined by a court of law.

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

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

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

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

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

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. § 638:20

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

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment or a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties or denial of insurance benefits.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

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

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

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

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