O'Fallon District 90

2024 EMPLOYEE BENEFIT GUIDE

WELCOME

At O'Fallon District 90, we think it is important for your employee benefits to keep up with you, which is why we offer an attractive suite of benefits. We regularly evaluate our benefit offerings and strive to provide you with a comprehensive and cost-effective program which lets you choose the coverage and services you need most.

This 2024 benefits guide provides you with an overview of your Medical, Dental, and Vision benefits, as well as summaries of additional benefits available to you.

To prepare for enrollment, please read this guide carefully to get answers to your questions and consider your options. Choose the plans which best fit your needs and make sure to include any family members who will be affected by your elections in the decision making process.

Our Human Resources team is here to help if you have specific questions or require assistance in the benefits enrollment process.

O'Fallon District 90
Bookkeeper

Carrie Bowen
cbowen@of90.net
618-632-3666

CONTACT INFORMATION

CARRIER		WEBSITE / EMAIL	PHONE
Medical Blue Cross Blue Shield	BlueCross BlueShield of Illinois	www.bcbsil.com	800-676-2583
HSA Bank of O'Fallon	Bank of O'Fallon	www.bankofallon.com	618-632-3595
HRA AssuredPartners	AssuredPartners	www.assuredpartners.com	314-373-2930
Dental Guardian	Guardian	www.guardianlife.com	800-541-7846
Vision Guardian	Guardian	www.guardianlife.com	800-541-7846
Life and AD&D Guardian	Guardian	www.guardianlife.com	800-541-7846
O'Fallon District 90 Bookkeeper Carrie Bowen	O'Fallon District 90	cbowen@of90.net	618-632-3666

ELIGIBILITY & ENROLLMENT PROCESS

ELIGIBILITY

You may enroll if you are an active full-time employee working a minimum of 30 hours per week.

Eligible dependents include your legal spouse or domestic partner and your children[1] up to age 26. Children will be covered on the Medical plan until the end of the month in which they turn 26.

ENROLLMENT PROCESS

WHEN TO ENROLL

If you are a newly hired full time employee, you are eligible to enroll in medical, dental and vision insurance coverage on your date of hire.

Unless you experience a qualifying life event, you cannot make changes to your benefits until the next open enrollment period. Please see the *Making Changes* textbox for additional information on qualifying life events.

HOW TO ENROLL

For your benefits enrollment, you will complete the attached applications and return to Carrie Bowen.

MAKING CHANGES

Internal Revenue Service (IRS) regulations stipulate that eligible employees may only make plan elections once a year. Elections are binding through 12/31/2024.

The following qualifying life events are reasons you may change your benefit election during the plan year provided you inform Human Resources in writing within 30 days of the event date:

- Marriage
- Birth, adoption, or placement of a child for adoption
- Divorce or legal separation
- Termination or commencement of your spouse's coverage in general when coverage is maintained through your spouse's plan.
- Shift from part-time to full-time status (or vice versa) by you or your spouse
- Death of spouse or dependent

Changes requested due to a "change of mind" cannot be allowed until the next open enrollment period.

[1] Children includes natural children, step-children, legally adopted children, or any child for which you have legal custody.

MEDICAL INSURANCE

BLUE CROSS BLUE SHIELD

Medical Insurance can help protect both your physical and financial health. Medical Insurance gives you access to a network of qualified medical professionals who are able to provide comprehensive, continuous, and coordinated heath care services. With regular visits to your doctor, you can detect and manage illnesses more easily. Medical Insurance also makes health care more affordable while protecting you from the financial repercussions of accidents and unexpected illnesses.

O'Fallon District 90 will continue to partner with Blue Cross Blue Shield in 2024 to provide Medical benefits for you and your family. New to your Medical plan for 2024…

BLUE CROSS BLUE SHIELD PROVIDER SEARCH

To get the highest level of coverage from your plan, use in-network healthcare providers. Receiving services from a participating in-network provider reduces your out-of-pocket healthcare costs. To confirm your provider is participating in-network or to search for in-network providers, follow these simple steps:

1. Go to www.bcbsil.com and click on the "Find a Doctor" button.
2. Login or search as a Guest by click the "Search for Doctor's as a Guest" button.
3. Enter your City, County, or Zip to find in-network physicians and medical professionals.
4. Select "Employer Plans" then Select the Participating Provider Organization (PPO) Network

O'Fallon District 90 utilizes the "Participating Provider Organization (PPO)" Medical network.

BlueCross BlueShield of Illinois

MEDICAL PLAN SUMMARY

	HRA PLAN	HIGH DEDUCTIBLE PLAN	HSA PLAN
PPO	**IN-NETWORK BENEFITS**		
Calendar Year Deductible			
Individual	$3,000*	$3,000	$2,500
Family	**$6,000**	**$6,000**	$5,000
Coinsurance (member / plan)	10% / 90% **	10% / 90%	20% / 80%
Out-of-Pocket Maximum			
Individual	$5,000***	$5,000	$5,000
Family	$10,000***	$10,000	$6,850
Common Services			
Wellness / Preventive	Covered in full	Covered in full	Covered in full
Primary Care Physician	$25 copay	$25 copay	Deductible then 20%
Specialist Physician	$50 copay	$50 copay	Deductible then 20%
Urgent Care	$50 copay	$50 copay	Deductible then 20%
Emergency Room	$300 copay	$300 copay	Deductible then 20%
Imaging & Lab Services			
Minor Imaging & Lab	Deductible then 10% coinsurance	Deductible then 10% coinsurance	Deductible then 20%
Major Imaging & Lab	Deductible then 10% coinsurance	Deductible then 10% coinsurance	Deductible then 20%
Hospital Services			
Inpatient	Deductible then 10% coinsurance	Deductible then 10% coinsurance	Deductible then 20%
Outpatient	Deductible then 10% coinsurance	Deductible then 10% coinsurance	Deductible then 20%

Percentages listed in the table represent the amount paid by the member.

IN-NETWORK PRESCRIPTION DRUGS—RETAIL			
ACA's Preventive Drug List	Covered in full	Covered in full	Covered in full
Generic	$12	$12	Deductible then 20%
Preferred brand	$30	$30	Deductible then 20%
Non-preferred brand	$50	$50	Deductible then 20%
Specialty	$50	$50	Deductible then 20%

Retail = up to 31-day supply. Mail Order = up to 90-day supply

MEDICAL RATES—26 pays / 20 pays			
	HRA PLAN (**26 pays / 20 pays**)	HIGH DED PLAN (**26 pays / 20 pays**)	HSA PLAN (**26 pays / 20 pays**)
Employee only	$25.19 / $32.74	$11.80 / $15.34	$0 / $0
Employee & Spouse	$375.73 / $488.45	$348.96 / $453.65	$203.66 / $264.76
Employee & Children	$354.45 / $460.78	$320.99 / $417.28	$180.64 / $234.83
Family	$417.02 / 542.13	$376.87 / $489.93	$220.30 / $286.39

Note: Medical premium payroll deductions are taken on a pre-tax basis.

For HRA plan Net Benefits-

*Deductible- Member pays first $500 ($0-500) District reimburses next ($501-2,500) up to $2,000 per member

**Coinsurance- Member pays 1st $800 coinsurance per member, District reimburses up to $1,200 per member

*** Net Major Medical OOP—$1,800 individual / $3,600 family (Does not include copays)

CONSUMER EDUCATION

BENEFITS OF A PRIMARY CARE PHYSICIAN

Coverage, choice, and convenience are factors each of us consider important when selecting a Medical plan. Choosing a Medical plan is the first step to being prepared when you need care.

An essential component of good medical care is the relationship you develop with your primary care physician. With a primary care physician, your health history is understood and your provider is better able to gauge changes in your health and detect potential medical concerns, which can lead to a better outcome.

PREVENTIVE CARE

One of the best decisions you can make for your health, and the health of your family, is to make sure to visit your doctor annually for routine physical exams, immunizations, and recommended screenings. Preventive care can help ensure that you and your family stay well and identify potential health issues early. With 100% coverage for in-network well-child, well-woman, and well-man care, O'Fallon District 90's Medical plan makes it easy and affordable for you and your family to get the preventive care you need.

GENERIC DRUG PROGRAMS

Costco Member Prescription Program (CMPP)

Use your Costco Card to save on prescriptions. If you are a Costco member simply show your Costco Card at Costco or network pharmacy for instant savings on prescriptions. Visit **costco.com/cmpp** for more information.

GoodRx.com

Compare prices, print free coupons, and save up to 80% on your prescriptions. For complete details visit **goodrx.com**.

Sam's Club

Join Sam's Club for exclusive access to their prescription savings program. Visit **samsclub.com/pharmacy/rxsavings** for complete details.

SingleCare.com

Find the lowest prices at participating pharmacies nationwide and save up to 80% on your prescriptions. Visit **singlecare.com** for more information.

Walgreens Prescription Savings Club

For complete details visit **walgreens.com** and search Prescription Savings Club. There you will find over 8,000 discounted prescription drugs, medications offered in all drug classes covering most common and chronic health conditions, pet prescriptions, and more. This program includes savings on diabetic supplies and insulin. Annual membership fees apply.

Walmart

Hundreds of generic prescription drugs are available priced at $4.00 for a 30-day supply and $10.00 for a 90-day supply at Walmart and Neighborhood Market Pharmacies nationwide. There are numerous over-the-counter medications included in the $4.00 program. For complete details visit the Pharmacy section at **walmart.com**.

CONSUMER EDUCATION

KNOW WHERE TO GO FOR CARE

When you need care, call your primary care physician first. Your primary care physician has easy access to your records, knows the bigger picture of your health, and may even offer same-day appointments to meet your needs. When seeing your primary care physician is not possible, it is important to know what in-network options are available to you.

CARE OPTIONS	COST	TREATMENT / SERVICES	AVERAGE AVAILABILITY
NurseLine	No Cost	Call the number on your Medical ID card to receive expert advice at no cost. NurseLine can help you decide where to go for medical care, find a doctor or hospital, and answer questions about medications.	24 hours 7 days a week
Virtual Visit	$	A virtual visit can treat the common cold, the flu, and other easily identifiable illnesses from the convenience of your tablet or smartphone.	24 hours 7 days a week
Convenience Care Clinic	$$	Convenience Care Clinics can treat skin rashes, minor injuries, and earaches and can administer flu shots and more.	8 AM—8 PM 7 days a week
Urgent Care	$$$	Urgent Cares can treat lower back pain, respiratory issues, stomach pain, infections, minor fractures, and more.	8 AM—8 PM 7 days a week
Emergency Room (ER)	$$$$	The ER is most costly option which is why it should only be used for true emergency care. ERs can treat everything including: chest pain, shortness of breath, severe asthma attacks, major burns, severe injuries, and more.	24 hours 7 days a week

COST ESTIMATOR TOOL

One You may pay a different amount for a procedure depending on which provider you select and where the procedure is performed.

Blue Cross Blue Shield's Cost Estimator will show you doctors and facilities may charge different amounts for the same services. Depending on what you are looking for, you could see a wide range of estimates for the same procedure. This information can help you make an informed decision on where to go for care.

Visit www.bcbsil.com, to register and search for the procedure you would like an estimate for.

HEALTH SAVINGS ACCOUNT

BANK OF O'FALLON

YOU MUST BE ENROLLED IN THE HSA MEDICAL PLAN IN ORDER TO ESTABLISH AND CONTRIBUTE TO A HEALTH SAVINGS ACCOUNT (HSA).

A Health Savings Account (HSA) is a savings account that allows you to set aside pre-tax payroll deductions to pay for qualified health care expenses. By using untaxed dollars in an HSA to pay for deductibles, copayments, coinsurance, and some other expenses, you may be able to lower your overall health care costs.

This year, O'Fallon District 90 will contribute $750 annually ($62.50 deposited monthly) to the HSAs of eligible employees who are enrolled in a QHDHP. It is important to account for the contributions from O'Fallon District 90 to ensure, between your contributions and O'Fallon District 90's contributions, you do not go over the IRS limit. If you have questions regarding your HSA please contact Carrie Bowen.

The 2024 annual contribution limit set by the IRS is $4,150 for individual coverage and $8,300 for family coverage.

COVERAGE TIER	2024 IRS ANNUAL CONTRIBUTION LIMIT
Employee Only	$4,150
Family	$8,300

Individuals age 55 and older or individuals who reach age 55 by December 31 can make catch-up contributions up to an additional $1,000/year.

MORE ABOUT YOUR HSA

You must be covered under a Qualified High Deductible Health Plan (QHDHP) to establish an HSA.

- There is no "use it or lose it" rule. All unused money will remain in your HSA for future use.
- You can contribute to your HSA on a pre-tax basis through payroll deductions.
- You cannot establish an HSA if…
  - You have a Health Care Flexible Spending Account (FSA)
  - You have insurance coverage under another plan, i.e. your spouse's employer, unless that secondary coverage is also a QHDHP
  - You are enrolled in Medicare or Tricare
  - You are claimed as a dependent under someone else's tax return

For more information regarding approved items and additional details about the HSA, visit the IRS website at **irs.gov**

Bank of O'Fallon

DENTAL INSURANCE
GUARDIAN

In addition to protecting your smile, Dental insurance helps pay for dental care and usually includes regular checkups, cleanings and x-rays. O'Fallon District 90 offers you the option between two Dental plans through Guardian that cover:

- Preventive Dental services such as routine exams and cleanings, fluoride treatments, sealant, and x-rays
- Basic services such as simple fillings and extractions, root canals, oral surgery, and periodontal maintenance
- Major services such as bridges, crowns, and dentures
- Orthodontia coverage available for eligible children.

IN-NETWORK DENTISTS CAN SAVE YOU MONEY

When using an in-network dentist, your out-of-pocket costs are lower. This is because the network of dentists has agreed to charge lower fees and your plan's network services cover a large share of the charges.

If you choose to use a dentist who does not participate in the DentalGuard Preferred network, your out-of-pocket expenses will be higher and you are subject to any charges above reasonable and customary and you may be balance billed.

Please refer to the summary plan description for detailed information on covered benefits.

GUARDIAN PROVIDER SEARCH

Visit **www.guardianlife.com** to register and log in to search for in-network Dental providers.

O'Fallon District 90 utilizes the "DentalGuard Preferred" Dental network.

Guardian

DENTAL PLAN SUMMARY

DENTALGUARD PREFERRED	LOW PLAN	HIGH PLAN
Calendar Year Deductible + Maximum		
Employee Only	$50	$50
Family limit	3 per family	3 per family
Maximum	$750	$1,500
Dental Benefits		
Preventive Care	80%	100%
Basic Care	70%	80%
Major Care	0%	50%
Orthodontia Benefits		
Orthodontia Coinsurance	Not covered	50%
Orthodontia Lifetime Maximum	Not covered	$1,000

Percentages listed in the chart represent the amount paid by the member at an in-network provider.

DENTAL RATES—20 OR 26 PAYS		
	LOW PLAN Employee Cost (**26 pays / 20 pays**)	**HIGH PLAN** Employee Cost (**26 pays / 20 pays**)
Employee Only	$9.84 / $12.79	$22.11 / $28.75
Employee + 1	$18.06 / $23.48	$40.59 / $52.77
Employee + 2 (Family)	$34.23 / $44.50	$58.97 / $76.66

Note: dental premium payroll deductions are taken on a pre-tax basis.

VISION INSURANCE
GUARDIAN

Having an annual eye exam is one of the best ways to make sure you are keeping your eyes healthy. Eye exams can help prevent and treat easily correctable vision problems which can cause permanent vision impairment. You have the option to enroll in the Vision plan through Guardian to save money on eligible vision care expenses, such as eye exam, glasses, and contact lenses.

THE IMPORTANCE OF SEEING IN-NETWORK PROVIDERS

Guardian's large Vision plan provider network offers you access to private practice optometrists and ophthalmologists, conveniently located retail chain providers, and discounted laser eye surgery from pre-screened providers. When you visit in-network providers the plan covers your vision care services at higher rates, and participating providers will submit your claim to Guardian.

GUARDIAN PROVIDER SEARCH

Visit **www.guardianlife.com** to search for in-network optical providers.

O'Fallon District 90 utilizes both the "VSP Choice" and the "Davis Vision" networks.

VISION PLAN SUMMARY

		VSP CHOICE NETWORK	DAVIS VISION
Exams Copay		$10	$10
Materials Copay		**$25**	$25
		You pay (after copay if applicable)	
Basic Exams		$0	$0 copay
Frames		80% of amount over $130	80% of amount over $130
Lenses	Single Vision	$0	$0
	Bifocal	$0	$0
	Trifocal	$0	$0
	Lenticular	$0	$0
	Fit & Follow-up	15% off UCR	No discounts
Contact Lenses *(in lieu of glasses)*	Elective	Amount over $130	85% of amount over $130
	Medically Necessary	$0	$0
Benefit Frequency			
Exam		Every calendar year	Every calendar year
Frames		Every two calendar years	Every two calendar years
Lenses		Every calendar year	Every calendar year
Contact Lenses *(in lieu of glasses)*		Every calendar year	Every calendar year

Costs listed in the chart represent the amount paid by the member at an in-network provider.

VISION RATES—20 OR 26 PAYS		
	Employee Cost- **26 pays / 20 pays**	Employee Cost- **26 pays / 20 pays**
Employee Only	$3.79 / $4.93	$3.79 / $4.93
Employee + 1	$5.76 / $7.48	$5.76 / $7.48
Employee + 2 (Famiyl)	$10.11 / $13.14	$10.11 / $13.14

Note: Vision premium

LIFE INSURANCE
GUARDIAN

BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

O'Fallon District 90 provides eligible full-time employees with Basic Life and AD&D coverage at no cost to you through Guardian in the amount of $10,000. You must name a beneficiary—the person or persons who will receive your Life insurance benefit upon your death. The benefit reduces by 35% at age 65, 60% at age 70, 75% at age 75, and 85% at age 80. AD&D insurance provides specified benefits for a covered accidental bodily injury which directly causes death or dismemberment.

VOLUNTARY LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

You may purchase additional Life and AD&D insurance through Guardian. You are responsible for paying the full cost of this coverage. If you choose to elect Voluntary Life and AD&D coverage for yourself, you may also purchase coverage on your dependents. See the table below for benefit amounts.

VOLUNTARY LIFE AND AD&D			
	Employee	**Spouse** *(Based on employee age)*	**Child(ren)** *14 days—23 years (25 if full-time student)*
Increments	$10,000	$5,000	$5,000
Guarantee Issue	$150,000	$50,000	$10,000
Maximum	$150,000	$75,000	$10,000

Evidence of Insurability (EOI) is required under the following circumstances and approval is not guaranteed:

- Late Entrant: you have previously waived the opportunity to elect this coverage when first eligible and are now enrolling for the first time.
- Current Participant: you currently are enrolled in this coverage and are requesting an increase to your current coverage amount.
- New Hire: you are requesting an amount over the Guarantee Issue when first eligible.

Guardian

AssuredPartners

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O'Fallon District 90

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O'Fallon District 90

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.

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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: _____

Waiver of Group Health Benefits – 2024

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, 2024 – December 31, 2024***, 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**

_____

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