



Dallas County

EMPLOYEE BENEFIT SUMMARY JULY 1, 2020 – JUNE 30, 2021



DISCLAIMER

The intent of this summary is to briefly highlight your benefits and NOT to replace your insurance contracts or booklets. The information has been compiled into summary form to outline the benefits offered by your company.

If this benefit summary does not address your specific benefit questions, please refer to the Customer Service Contact page of this booklet. This page will provide you with the information you need to contact the specific insurance carriers and/or your Human Resources Department for additional assistance.

The information provided in this summary is for comparative purposes only. Actual claims paid are subject to the specific terms and conditions of each contract. This benefit summary does not constitute a contract.

The information in this booklet is proprietary. Please do not copy or distribute to others.

Contained within this document is your annual Medicare Part D notice as required by the Centers for Medicare & Medicaid. Please see the table of contents for page number.

Created by Holmes Murphy & Associates for Dallas County.



TABLE OF CONTENTS

Eligibility	5
Medical Insurance	6
Wellmark: Virtual/Telehealth Services	15
Wellmark: myWellmark	17
Wellmark: Be Drug Smart	19
Wellmark: Blue365	21
Dental Insurance	23
Vision Insurance	24
Flexible Spending Accounts	26
FSA Tax Savings Worksheets	28
FSA Eligible Expenses	29
Basic Life / Accidental Death & Dismemberment	32
Voluntary Term Life Insurance	33
Voluntary Short Term Disability Insurance	34
Long Term Disability Insurance	36
Reliance Standard: Travel Assistance	37
2020 Monthly Premiums	41
Medicare Part D Notice – Creditable Coverage	42
HIPAA Special Enrollment Notice	44
Women’s Health & Cancer Rights Act of 1998	45
Newborns’ and Mother’s Health Protection Act	45
Marketplace Notice	46
Customer Service Contact Information	47
Amplifon Hearing Health Care	49

WHO IS ELIGIBLE?

If you are a Dallas County full-time employee (as defined by the employee handbook or collective bargaining agreement, elected officials, and individuals otherwise eligible according to the minimum standards of the Affordable Care Act), you are eligible to enroll in the benefits described in this guide. Your family members are eligible for medical, dental and vision coverage through Dallas County. Eligibility for new hires begins the first of the month following 30 days of employment.

HOW TO ENROLL

The first step is to review your current benefit elections. Verify your personal information and make any changes if necessary. Make your benefit elections. Once you have made your elections, you will not be able to change them until the next open enrollment period unless you have a qualified change in status.

WHEN TO ENROLL

The benefits you elect during open enrollment will be effective from July 1, 2020 through June 30, 2021.

WHEN TO MAKE CHANGES

Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period. Qualified changes in status include: marriage, divorce, legal separation, domestic partnership status change, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, change in residence due to an employment transfer for you, your spouse or domestic partner, commencement or termination of adoption proceedings, or change in spouse's or domestic partners benefits or employment status, reduction in hours, or marketplace open enrollment. See HIPAA Special Enrollment Rights later in this packet for notification requirements.

MEDICAL INSURANCE

Wellmark Blue Cross Blue Shield

Alliance Select PPO

This chart gives a side-by-side look at the amounts you pay when you use in-network and out-of-network providers. For a complete listing of providers, visit www.wellmark.com, click on "Find a provider or facility" under the Menu, and search by ID number or by network (select the "Wellmark Blue PPO" plan).

Plan Feature	In-Network	Out-of-Network ⁽¹⁾
Deductible (Calendar Year)	\$200 single \$400 family	
Coinsurance	20%	30%
Out-of-Pocket Maximum (Calendar Year)	\$1,500 single \$3,000 family	
Lifetime Maximum	Unlimited	
Office Visit*	\$15 copayment	Deductible, 30% coinsurance
Preventive Care Services**	Covered at 100%	Covered at 100%
Chiropractic Services	\$15 copayment	Deductible, 30% coinsurance
Urgent Care	\$15 copayment	Deductible, 30% coinsurance
Emergency Room	Deductible, 20% coinsurance	Deductible, 20% coinsurance
Facility Services	Deductible, 20% coinsurance	Deductible, 30% coinsurance
Outpatient Services	Deductible, 20% coinsurance	Deductible, 30% coinsurance
Mental Health & Substance Abuse Services		
Inpatient / Outpatient	Deductible, 20% coinsurance	Deductible, 30% coinsurance
Office Visit	\$15 copayment	Deductible, 30% coinsurance
Prescription Drug Coverage ⁽²⁾ (Blue Rx Complete formulary)	\$10 Tier One / \$40 Tier Two / \$60 Tier Three / \$100 Tier Four <i>(Specialty drugs are covered only when obtained through the Specialty Pharmacy Program)</i>	
Virtual/Telehealth Services ⁽³⁾	\$5 copayment	Deductible, 30% coinsurance

- (1) For out-of-network providers, the member may incur some charges above usual, customary and reasonable, which are the responsibility of the member and do not apply to the out-of-pocket maximum.
- (2) When a brand drug is obtained and there is an equivalent generic drug available, the member is responsible for paying their payment obligation for the brand name drug (i.e. highest payment application) and any remaining cost difference up to the maximum allowed fee for the brand name drug except when the provider writes "Dispense as Written" (in this case, the member pays only the appropriate payment application).
- (3) In-network virtual/telehealth services reflect member cost share for Doctor On Demand providers. In-network virtual/telehealth services for non- Doctor On Demand providers apply standard Office Visit member cost share.

***Waive office visit copayment and apply deductible & coinsurance for office surgery. Benefits shown apply to office/clinic practitioners. The cost you pay for facility services depends on how the facility bills the services.**

NOTE: Deductible, Coinsurance, and Copayments (medical and prescription drug) apply towards the Out-of-Pocket Maximum.



Dallas County 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, visit www.wellmark.com or call 1-800-622-0005. 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 1-800-622-0005 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$200 person/\$400 family per calendar year.	Generally, you must pay all 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. Well-child care, preventive care, in-network independent labs for mental health/substance abuse, in-network prosthetic limbs, mammograms, laboratory services performed at Dallas County Hospital and services subject to health and drug card copayments 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. There are no other deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Health: \$1,500 person/\$3,000 family per calendar year. Drug Card: \$1,500 person/\$3,000 family per calendar year. The In-Network health and drug card out-of-pocket maximum amounts accumulate together.	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-billed 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.

Important Questions	Answers	Why this Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.wellmark.com or call 1-800-622-0005 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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 In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$15 <u>copay</u> per date of service	30% <u>coinsurance</u>	Waive <u>copay</u> and apply <u>deductible</u> and <u>coinsurance</u> to office surgery.
	<u>Specialist</u> visit	\$15 <u>copay</u> per date of service	30% <u>coinsurance</u>	Waive <u>copay</u> and apply <u>deductible</u> and <u>coinsurance</u> to office surgery.
	<u>Preventive care/screening/immunization</u>	No charge	0% <u>coinsurance</u>	One preventive exam and one gynecological exam with Pap smear per calendar year. Waive cost-share for unlimited mammograms. Well-child care is covered to age 7. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	For a test in a <u>provider's</u> office or clinic, your cost is included in the cost-share listed above. Waive cost-share for mammograms. Waive cost-share on <u>in-network</u> independent lab services for mental health/substance abuse. Waive cost-share for lab services performed at Dallas County Hospital when labs are the only services billed.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	For a test in a <u>provider's</u> office or clinic, your cost is included in the cost-share listed above.

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-622-0005.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at www.wellmark.com/prescriptions.</p>	Tier 1	\$10 <u>copay</u> per prescription	\$10 <u>copay</u> per prescription	<p>Drugs listed on Wellmark's Blue Rx Complete Drug List are covered. Drugs not on this Drug List are not covered. For out-of-network <u>prescription drugs</u>, you may be balance billed.</p> <p>1 <u>copay</u> for 30-day supply.</p> <p>1 <u>copay</u> for 90-day supply (Retail and Mail order maintenance).</p> <p>Waive cost-share for oral chemotherapy medications.</p> <p>Waive cost-share for over-the-counter (OTC) medications when prescribed by a physician.</p> <p>Waive cost-share for immunizations and flu vaccines obtained at a participating pharmacy under your drug card plan.</p> <p><u>Specialty drugs</u> are covered only when obtained through the Specialty Pharmacy Program.</p> <p>See wellmark.com/prescriptions for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your plan.</p>
	Tier 2	\$40 <u>copay</u> per prescription	\$40 <u>copay</u> per prescription	
	Tier 3	\$60 <u>copay</u> per prescription	\$60 <u>copay</u> per prescription	
	Tier 4	\$100 <u>copay</u> per prescription	\$100 <u>copay</u> per prescription	
	Specialty drugs	Same as cost-share above depending on drug category.	Not Covered	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----
	Physician/surgeon fees	20% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----
	Emergency room care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	For <u>emergency medical conditions</u> treated out-of-network, you may be balance billed.
<p>If you need immediate medical attention</p>	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	For covered non-emergent situations, out-of-network ambulance services are NOT reimbursed at the in-network level. The member may be balance billed for any out-of-network service.
	Urgent care	\$15 <u>copay</u> per date of service	30% <u>coinsurance</u>	-----None-----
	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Reduction for failure to precertify out-of-network services will not exceed \$500 per admission.
<p>If you have a hospital stay</p>	Physician/surgeon fees	20% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-622-0005.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$15 <u>copay</u> per date of service Facility: 20% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----
	Inpatient services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Reduction for failure to precertify out-of-network services will not exceed \$500 per admission.
If you are pregnant	Office visits	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply to certain preventive services. For any in-network services that fall outside of routine obstetric care, the office visit benefits shown above may apply.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Benefits shown reflect OB/GYN practitioner services which are typically globally billed at time of delivery for pre-natal, post-natal and delivery services.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----
	Home health care	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Limit of 100 days per calendar year.
	Rehabilitation services	Office: \$15 <u>copay</u> per date of service Facility: 20% <u>coinsurance</u>	30% <u>coinsurance</u>	Waive office <u>copay</u> and apply <u>deductible</u> and <u>coinsurance</u> to in-network inhalation/respiratory therapies and cardiac rehabilitation.
If you need help recovering or have other special health needs	Habilitation services	Office: \$15 <u>copay</u> per date of service Facility: 20% <u>coinsurance</u>	30% <u>coinsurance</u>	Waive office <u>copay</u> and apply <u>deductible</u> and <u>coinsurance</u> to in-network inhalation/respiratory therapies and cardiac rehabilitation.
	Skilled nursing care	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Limit of 60 days per calendar year. Reduction for failure to precertify out-of-network services will not exceed \$500 per admission.
	Durable medical equipment	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Trusses are covered.
	Hospice services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-622-0005.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
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-----

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-622-0005.

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
- Bariatric surgery
- Cosmetic surgery
- Custodial care - in home or facility
- Dental care - Adult
- Dental check-up
- Extended home skilled nursing
- Eye exam
- Glasses
- Hearing aids
- Infertility treatment
- Long-term care
- Routine eye care - Adult
- Routine foot care
- Weight loss programs

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

- Applied Behavior Analysis therapy-covered subject to state mandate through age 18 subject to annual limits (short term intermittent home skilled nursing (applies to home health care limit))
- Chiropractic care
- Most coverage provided outside the U.S.
- Private-duty nursing -

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cclio.cms.gov.

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, you can contact: Wellmark at 1-800-622-0005.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

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

Wellmark Blue Cross and Blue Shield of Iowa is an Independent Licensee of the Blue Cross and Blue Shield Association.

This contains only a partial description of the benefits, limitations, exclusions and other provisions of the health care plan. It is not a contract or policy. It is a general overview only. It does not provide all the details of coverage, including benefits, exclusions, and policy limitations. In the event there are discrepancies between this document and the Coverage Manual, Certificate, or Policy, the terms and conditions of the Coverage Manual, Certificate, or Policy will govern.

About These Coverage Examples:



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

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

- The plan's overall deductible \$200
- PCP copayment \$15
- Hospital(facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$80
<u>Coinsurance</u>	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,540

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

- The plan's overall deductible \$200
- Specialist copayment \$15
- Hospital(facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$90
<u>Copayments</u>	\$1,400
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$200
The total Joe would pay is	\$1,690

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

- The plan's overall deductible \$200
- Specialist copayment \$15
- Hospital(facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$80
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$480

The amounts shown in the maternity claim example above are based on amounts using a single per person deductible. Some plans may actually apply a two-person or family deductible to maternity services for the mother and newborn baby.

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

Required Federal Accessibility and Nondiscrimination Notice



Discrimination is against the law

Wellmark complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Wellmark does not exclude people or treat them differently because of their race, color, national origin, age, disability or sex.

Wellmark provides:

- Free aids and services to people with disabilities so they may communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, call 800-524-9242.

If you believe that Wellmark has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Wellmark Civil Rights Coordinator, 1331 Grand Avenue, Station 5W189, Des Moines, IA 50309-2901, 515-376-4500, TTY 888-781-4262, Fax 515-376-9073, Email CRC@Wellmark.com. You can file a grievance in person, by mail, fax or email. If you need help filing a grievance, the Wellmark Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail, phone or fax at: U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F, HHH Building, Washington DC 20201, 800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意: 如果您说普通话, 我们可免费为您提供语言协助服务。请拨打 800-524-9242 或 (听障专线: 888-781-4262)。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية، المجانية. اتصل بالرقم 800-524-9242 أو (خدمة الهاتف النصي: 888-781-4262).

ສິ່ງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາ ໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ທີ. (TTY: 888-781-4262.)

주의: 한국어 를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें: अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, नि:शुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

ATTENTION : si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deutsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 oder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย เรายังมีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

တောိုးသုဂ်ညါ-နုးမုာ်ကတိာ်ကေညါကိဂ်.ကိဂ်တိာ်မတတိာ်ဖဲတိာ်မတတိာ်.လတတဘိလတဘိလ.ဆိဂ်လနဂ်လိာ်.ဆဲးကိးဆူ ၈၀၀-၅၂၄-၉၂၄ မုတမုာ် (TTY: ၈၈၈-၇၈၁-၄၂၆) တက့ာ်.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस्।

ማሰሰቢያ: አማርኛ የሚናገሩ ከሆነ: የቋንቋ አገዛ አገልግሎቶች: ከክፍያ ነፃ: ያገኙሉ:: በ 800-524-9242 ወይም (በTTY: 888-781-4262) ደውሎ ያነጋግሩ::

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maada. Hebir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) quunnamaa.

УВАГА! Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телетайп: 888-781-4262).

Ge': Diné k'éhjí yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Kojí' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)

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FEELING BETTER SHOULD BE EASY.

Visit a doctor on your smartphone, tablet or computer virtually anywhere, any time.

dr. on demand

GETTING STARTED IS EASY.

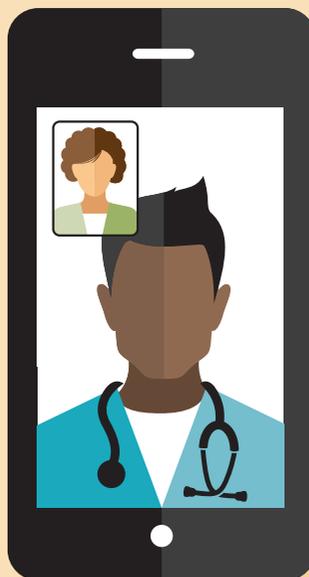
- 1 Download the Doctor On Demand™ app or visit DoctorOnDemand.com.
- 2 Have your Wellmark member ID card ready.
- 3 Create an account or sign in.

¹ Members with a plan on the Wellmark Synergy HMO Network have access to UleCare®, an online medical service operated by University of Iowa Health System.

² Includes treatment for certain psychological conditions, emotional issues and chemical dependency. Services performed by psychologists are covered. Psychiatry, which may include the use of prescription drugs, is not covered. For more information, call Wellmark at the number on your ID card.

SEE A DOCTOR IN MINUTES

Getting sick is bad enough without having to get out of bed to see a doctor. With Doctor On Demand, you and your family members can connect face-to-face with a board-certified doctor 24 hours a day, 7 days a week, 365 days a year.¹



Get treatment for:

- Cold and flu
- Bronchitis and sinus infections
- Urinary tract infections
- Sore throats
- Allergies
- Fever
- Headache
- Pink eye
- Skin condition
- Mental health²

Questions? Call 800-997-6196.

WITH DOCTOR ON DEMAND, WELLMARK MEMBERS GET MORE. IT'S CONVENIENT AND EASY. AND YOUR BENEFITS APPLY AUTOMATICALLY.

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Wellmark's virtual health care visit benefit is made available through an independent company, Doctor On Demand, Inc., and the telemedicine services are provided by licensed physicians practicing within a group of independently owned professional practices. Doctor On Demand, Inc. does not itself provide any physician, mental health or other healthcare provider services. Doctor On Demand operates subject to state laws. Doctor On Demand is not intended to replace an annual, in-person visit with a primary care physician.

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HEALTH INSURANCE MADE EASY

Your personal health care information is at your fingertips with myWellmark® — no matter your location — with tools, resources and insights to help you manage health care spending and live a healthier life.

Use myWellmark to better understand and get the most from your health insurance benefits. With myWellmark, you can:



Estimate your cost of care for procedures and services before you go



View detailed claims information, including cost breakdown and status tracker



Track and organize your family's medical expenses



Receive electronic versions of your Explanation of Benefits (EOB)



Find a trusted provider in your plan's network



See relevant information related to your specific coverage

Get more from your health plan by registering at [myWellmark.com](https://mywellmark.com).

LEARN MORE 

myWellmark streamlines your health insurance information and makes it easier to find what you need, when you need it, on any device.

GET THE INFORMATION YOU NEED

Using your specific health plan benefits and a powerful suite of tools, myWellmark helps you make informed decisions:

- Find an in-network provider near you
- Know what your visits will cost before you go
- See your doctor's quality score and patient rating
- Read reviews from other patients and leave your own

KEEP TABS ON CLAIMS AND SPENDING

On your personalized myWellmark, you'll see an at-a-glance overview of recent claims activity and whether a claim is paid, pending or denied (and why). Need more details, including your share of the cost? Just click on any claim.

KNOW YOUR BENEFITS INSIDE AND OUT

When it comes to your coverage and benefits, myWellmark has you covered. You're able to:

- Keep track of services you've used
- Determine potential copay or coinsurance costs for in- and out-of-network services
- See how close you are to meeting your deductible and out-of-pocket maximums
- Choose how you would like to receive communications and important documents related to your benefits



Your health care — at your fingertips. Get easy, on-the-go access to tools, resources and insights that help you manage health care spending and live a healthier life. It's all available in the myWellmark mobile app. The best part? It's free.

WITH THE MOBILE APP, YOU CAN:

- Log in securely using fingerprint or facial recognition technology*
- View in-network doctors and hospitals
- Get health answers over the phone with one tap of a finger
- Connect directly to your provider's office or another health professional
- Find the closest doctor or facility, and get driving directions
- View and email your mobile ID card for easy, on-the-go access

*If supported by your mobile device.

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MAKE YOUR VISIT TO THE PHARMACY SURPRISE-FREE

The Drug Search Tool on Wellmark.com helps you make smart decisions at the pharmacy. It guides you through what prescription drugs are covered — and how they're covered — by your insurance plan.

HOW IT WORKS

Use the tool to search for a prescription drug:

1. LEARN THE DRUG TIER OR LEVEL

The drug's tier or level



YOU PAY \$



YOU PAY \$\$



YOU PAY \$\$\$



YOU PAY \$\$\$\$



YOU PAY \$\$\$\$\$



What's a drug tier or level?

The drugs covered by your insurance plan are grouped into tiers or levels. Your drug's tier or level determines how much you'll pay for it at the pharmacy. The higher the tier or level, the more your drug will cost.

Want a lower cost option?

Just use the **Drug Search Tool** to find a lower-cost drug equivalent or a lower-tier alternative.

2. LEARN ABOUT COVERAGE DETAILS



If it **requires prior approval** before filling



If there are **requirements about drug amounts** allowed per month



If the **drug is preventive**

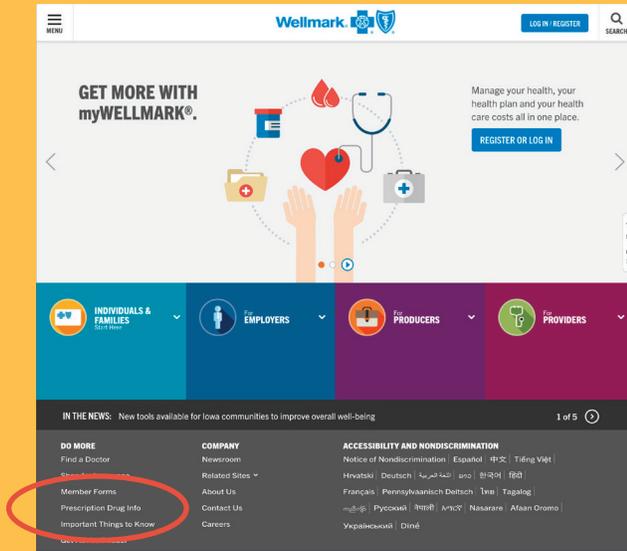
3. LEARN ABOUT DRUG DETAILS



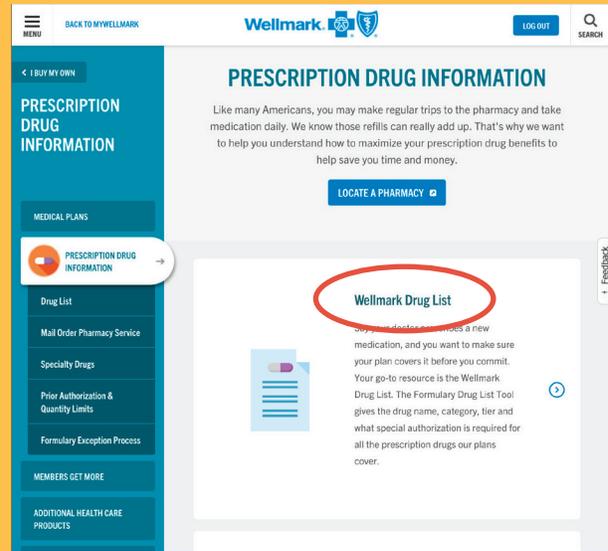
- Common uses
- How to take it
- Possible side effects
- Drug interactions
- What it looks like

HOW TO  USE IT

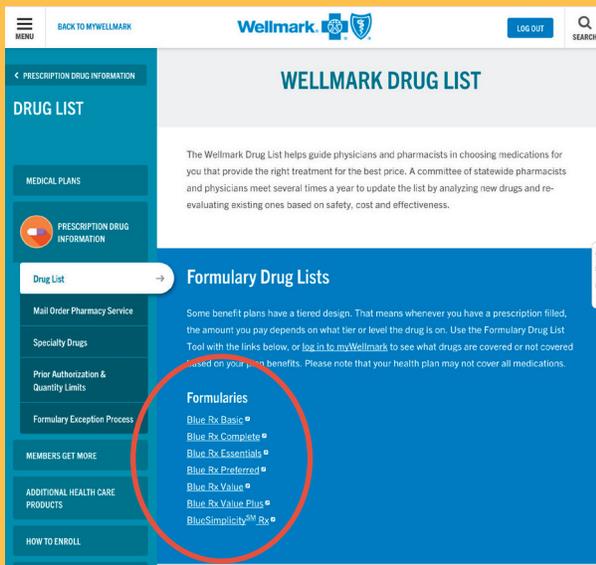
HOW TO USE THE DRUG SEARCH TOOL ON WELLMARK.COM



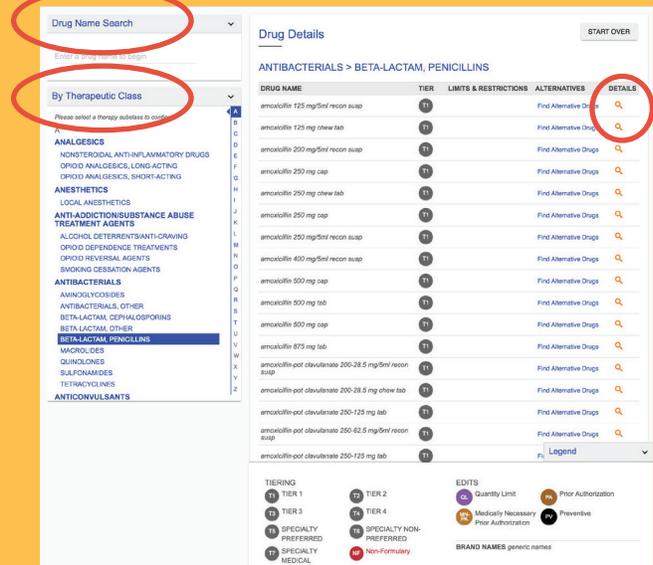
1. Scroll to the **bottom of the page** and click on **Prescription Drug Info.**



2. Click on **Wellmark Drug List.**



3. Select your **formulary plan name** from the list. Don't know it? Call the customer service number on the back of your Wellmark ID card.



4. Search for your drug by **drug name or therapeutic class.** Get **more information about your drug** by clicking the search icon next to it.

Ready to find out how much your drug will cost at the pharmacy? Use Wellmark's **Check Drug Cost and Coverage tool**, available through myWellmark® at Wellmark.com. This tool is just one of many resources available to help you get the most out of your pharmacy benefits.



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WHEN DOES AMY USE HER HEALTH INSURANCE? EVERY TIME SHE GOES FOR A WALK.

Most people are grateful for insurance when something bad happens. But Wellmark members are grateful for their insurance 365 days of the year. That's because they have Blue365®. Members get exclusive discounts on wellness products and services they use all the time, like fitness trackers, eyeglasses and athletic shoes.

SIGN UP TODAY AT [WELLMARK.COM/BLUE365](https://www.wellmark.com/blue365)



Just by being a Wellmark member, you have access to Blue365. When you sign up, you get exclusive discounts for wellness products and services you use every day.

Savings are just a click away

Register for Blue365 at Wellmark.com/Blue365. It's free and you can start saving right away. Browse the discounts and be the first to know about the latest deals to hit Blue365 through a weekly email sent right to your inbox.

Wondering what types of deals are available? Here are just a few ways you can save money while meeting your health and personal goals:



APPAREL AND FOOTWEAR. Save up to 20 percent on Reebok® shoes or 30 percent on Skechers®.



FITNESS. Get access to a network of gyms near you for just \$29 per month or track your health with discounted wearables from FitBit®, Garmin® and Polar®.



HEARING AND VISION. Save an average of \$1,100 on LASIK eye surgery. Or, get eyeglass frames and hearing aids at a discounted rate.



HOME AND FAMILY. Switch to Sprint and get up to a \$200 pre-paid gift card. Or, make sure your pet's health is covered with 10 percent off pet insurance.



NUTRITION. Eat well for less with a free 3-month Jenny Craig® membership.



TRAVEL. Travel for less with an extra 10 percent off hotels through Hotels.com™ and 20 percent off Fairmont Hotels and Resorts.



Wellmark members get more

Blue365 isn't the only way you get more for being a Wellmark member. As part of your health plan, you also have access to products and services like:

- **myWellmark®** — your one-stop shop for tools and resources to help you get the most out of your health care.
- **BeWell 24/7SM** — get connected with a real person who can help you with a variety of health-related concerns. Just call 844-84-BEWELL (239355).
- **Doctor On Demand®** — see a board-certified doctor from virtually anywhere using a smartphone, tablet or computer.



Register for Blue365 today!

Go to Wellmark.com/Blue365. All you need to register is a valid email address and the first three characters of your Wellmark ID number.

Blue365 is a discount program available to members who have medical coverage with Wellmark. This is not insurance.

Visit Wellmark.com/Blue365 for a full list of deals and discounts available to you.

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DENTAL INSURANCE

Wellmark Blue Cross Blue Shield

Blue Dental

This chart gives a look at the amounts you pay when you use an in-network provider. For a complete listing of providers, visit www.wellmark.com, click on "Find a provider or facility" under the Menu, click on "Search the Blue Dental network" under Find a Dentist, and search by the "Blue Dental" plan.

Type of Service	In-Network
Deductible (Calendar Year)	\$25 single \$75 family
Diagnostic & Preventive Services <ul style="list-style-type: none"> - Dental Cleanings - Preventive Evaluations - Fluoride Applications - X-rays - Sealant Applications - Space Maintainers 	Deductible waived, covered at 100%
Routine & Restorative Services <ul style="list-style-type: none"> - Emergency Treatment - General Anesthesia/Sedation - Routine Oral Surgery - Endodontics (Root Canals) - Periodontics (Gum & Bone Diseases) - Fillings - High Cost Restorations (Crowns, Inlays, Onlays, Posts & Cores) 	Deductible, 20% coinsurance
Major Services <ul style="list-style-type: none"> - Prosthetics (Bridges & Dentures) 	Deductible, 50% coinsurance
Orthodontia (Covers dependent children age 8 up to 19)	Deductible waived, 50% coinsurance
Plan Maximums	\$1,500 per calendar year for Diagnostic & Preventive, Routine & Restorative, and Major Services <ul style="list-style-type: none"> • Per insured person \$1,000 per lifetime for Orthodontia <ul style="list-style-type: none"> • Per dependent child

NOTE: A 12-month waiting period applies to Endodontics, Periodontics, High Cost Restorations, Prosthetics, and Orthodontia.

VISION INSURANCE

Avesis

Enhanced Plan

This chart gives a side-by-side look at the amounts you pay when you use in-network and out-of-network providers. For a complete listing of providers, visit www.avesis.com, click on "Provider Search" on the toolbar, select "Vision" as the Provider Type and enter your information to locate a provider in your area.

Type of Service	In-Network	Out-of-Network Reimbursement
Vision Exam (includes Refraction)	\$10 copayment	Up to \$35
Materials	\$25 copayment	n/a
Frames	\$35 wholesale allowance (Up to \$100 retail value) Up to 20% discount above frame allowance	Up to \$45
Standard Spectacle Lenses		
Single	Covered in full after copayment	Up to \$25
Bifocal	Covered in full after copayment	Up to \$40
Trifocal	Covered in full after copayment	Up to \$50
Lenticular	Covered in full after copayment	Up to \$80
Standard Progressives	\$50 allowance Up to 20% off retail	Up to \$40
Other Lens Options	Up to 20% discount	n/a
Contact Lenses (in lieu of Frame and Spectacle Lenses)		
Elective	\$110 allowance	Up to \$110
Medically Necessary	Covered in full (Prior authorization required)	Up to \$250
Refractive Laser Surgery	\$100 Lifetime Allowance Provider discount up to 25%	\$100 Lifetime Allowance
Frequency		
Vision Exam		Once every 12 months
Lenses or Contact Lenses		Once every 12 months
Frame		Once every 24 months

Member Technology

Using and managing your healthcare benefits should fill you with a sense of wellbeing. Avēsis makes it easy with our Member Portal. The first step is signing up. Visit www.avesis.com, and click Members. The only thing you'll need is information you already know, like your name and date of birth. Once you're registered, you'll have the secure access you seek to everything you need for clear vision!

Print ID Cards

Didn't get one in the mail yet? Need an extra? Lost your card? Print a replacement easily right from our portal. But remember: you never need to show your ID to receive benefits.

See Claims Status

If you've submitted a claim for an out-of-network service, you can see its progress here. You can also check to see whether Avēsis has paid your vision care provider.

View Benefit Summaries

See the full range of benefits—from eye exams to LASIK—of your plan for you and all non-adult members covered under your plan.

Check Eligibility

Wonder when you can get that pair of frames you've been longing for? See when you had service last and when you'll be eligible again!

Search for Providers

Find your most convenient provider from among the tens of thousands who participate with us. Search by mile radius, provider name, city and state, and more.

Nominate Providers

Don't see your eye doctor on our list? Nominate one using a handy form on our website. Give us as much information as you can, and we'll do the rest!

Learn More

Good ocular health begins with you. Learn more about sight through our FAQs, glossary and vital vision facts.

Need Assistance?

Our Customer Care Center can be reached at 800-828-9341, Monday through Friday, 7:00 a.m. to 8:00 p.m. EST.

FLEXIBLE SPENDING ACCOUNTS (FSA)

Take Care by WageWorks

FSAs provide you with an important tax advantage that can help you pay health care and dependent care expenses on a pre-tax basis. By anticipating your family's health care and dependent care costs for the next year, you can actually lower your taxable income.

Plan Overview

Pre-Tax Premium Benefits

This plan allows you to fund several of your premium contributions with pre-tax dollars and to fund either a Health Care Reimbursement Account and/or Dependent Care Reimbursement Account. Your contributions are deducted from your gross wages before FICA, Federal and State taxes are deducted. You save money because you are taxed at a reduced income level. Your taxes are calculated after your premiums and reimbursement account monies are deducted from your gross wages.

Health Care Reimbursement Accounts

This plan allows you to defer pre-tax dollars into a Health Care Reimbursement Account to pay for certain IRS-approved medical care expenses not covered by your insurance plan with pre-tax dollars. Some examples include:

- Deductible, coinsurance and copayments
- Over the counter medications – with prescription
- Dental services and orthodontia
- Vision services, including contact lenses, contact lens solution, eye exams and eyeglasses
- Hearing services, including hearing aids and batteries

Medical Care Maximum: \$2,550

Dependent Care Reimbursement Accounts

This plan allows you to defer pre-tax dollars into a Dependent Care Reimbursement Account. You may request reimbursement as you incur expenses to provide day care for qualified dependents: children under age 13, or an older disabled dependent child, or a disabled adult.

Dependent Care Maximums: \$5,000 if married filing jointly or head of household;
\$2,500 if married filing single.

Plan Provisions

Note: Your election in the Dallas County 125 Flexible Benefit Plan is irrevocable for the entire plan year (July 1st through June 30th) without a qualifying change in status (i.e. birth, adoption, divorce, job status change, etc.) Please be advised that any unused FSA monies will be forfeited back to the Plan at the end of the plan year and/or grace period.

Grace Period

Your FSA plan has a 2 ½ month extension of time (at the end of the 12 month plan year), in which you may continue to incur eligible Health Care FSA expenses.

Claim Submission

Claims may be filed by mailing, faxing, or online. Please be aware that your plan has a 90-day run out period, after the end of the plan, where you may still file claims. Remember that the expense, however, must have been incurred during the plan year.

FLEXIBLE SPENDING ACCOUNTS

How do Flexible Spending Accounts Work?

Flexible Spending Accounts (FSAs) are like personal bank accounts. They allow you to set aside money for healthcare and/or dependent care expenses on a pre-tax basis. You can enroll in a Healthcare FSA and/or a Dependent Day Care FSA. Your election will cover you from your enrollment date through the end of the plan year unless you have a change in family status.

You can elect to have a portion of your salary withheld on a pre-tax basis for health or dependent care expenses you incur during the plan year. The funds will be placed into an account to be used during the year. If you contribute to both FSAs, you cannot use amounts contributed to one account to pay expenses eligible for payment from another account. For example, you cannot pay medical expenses from your Dependent Day Care FSA.

HEALTH CARE FSA

During annual enrollment, you may elect to contribute monies into the Health Care FSA during the coming plan year. The amount you elect to set aside will be deducted from your paycheck in equal installments during the plan year.

Eligible health care expenses include copayments, deductibles, coinsurance, over-the-counter medications, certain orthodontic procedures and other health-related expenses incurred by you or a family member.

DEPENDENT DAY CARE FSA

You can contribute up to \$5,000 each year to the Dependent Day Care FSA to pay for dependent day care expenses. The amount you elect to set aside will be deducted from your paycheck in equal installments during the coming plan year.

Eligible dependent day care expenses are only those incurred for the care of a child under 13 years of age (or a disabled child older than age 13) who qualifies as your dependent for tax purposes; or, anyone you can claim as a dependent, such as an elderly parent or disabled spouse.

USE IT OR LOSE IT

It is very important that you estimate accurately when determining how much to contribute to either FSA. FSAs can provide significant tax advantages for employees when the contributions are made on a pre-tax basis. For this reason, the IRS requires that you use all the money in your account(s) during the plan year (with the exception of the Grace Period permitted under the Health Care FSA). Any money remaining in your account(s) at the end of the plan year will be forfeited.

FSA TAX SAVINGS WORKSHEETS

What will you do with the money you save by participating in the Flex Plan?

Use this worksheet to help determine your potential tax savings.

FSA Reimbursement Account Expenses							
Medical		Vision		Dental		Dependent Care	
Deductibles	\$	Exams	\$	Routine Exam	\$	Children	\$
Copays	\$	Eye Surgery	\$	Fillings/ Crowns	\$	Adults	\$
Prescriptions	\$	Lenses/ Frames	\$	Orthodontics	\$		
Other	\$	Contacts	\$	Other			
Total	\$	Total	\$	Total	\$	Total	\$

Estimated Annual Expenses & Tax Savings	
Total Medical + Vision + Dental Expenses	\$ _____
Total Dependent Care Expenses	+ \$ _____
Total Expenses	\$ _____
Tax Bracket Percentage (see below)	X _____
Annual Tax Savings	\$ _____
Number of Pay Periods	/ _____
Estimated Savings Per Pay Check	\$ _____

Tax Estimate Table	
Annual Household Earnings	Estimated Tax Rate
\$0 - \$19,050	10%
\$19,051-\$77,400	12%
\$77,401 - \$165,000	22%
\$165,001 - \$315,000	24%
\$315,001 - \$400,000	32%
\$400,001 - \$600,000	35%
> \$600,000	37%

KNOW YOUR BENEFITS.

From Dallas County



Flexible Spending Account Eligible Expenses

Which expenses can be reimbursed by an FSA?

Your Dallas County Health Care Reimbursement Flexible Spending Account lets you pay for medical care expenses not covered by your insurance plan with pre-tax dollars. The expenses must be primarily to alleviate a physical or mental defect or illness, and be adequately substantiated by a medical practitioner. The products and services listed below are examples of medical expenses eligible for payment under your Dallas County FSA, to the extent that such services are not covered by your medical and dental insurance plan.

Unfortunately, **we cannot provide a definitive list of “qualified medical expenses.”** A determination of whether an expense is for “medical care” is based on all the relevant facts and circumstances. To be an expense for medical care, the expense has to be primarily for the prevention or alleviation of a physical or mental defect or illness.

On March 27, 2020, the president signed the Coronavirus Aid, Relief and Economic Security Act ([CARES Act](#)) into law. The CARES Act repealed the Medicine Cabinet Tax provision of the Affordable Care Act, expanding the list of qualifying expenses that can be purchased with an FSA. Under the CARES Act, the definition of a qualifying medical expense now includes certain over-the-counter medications and products, including cold and flu medicine, allergy medication and menstrual products.

- Abortion
- Acupuncture
- Alcoholism treatment
- Ambulance
- Annual physical examination
- Artificial limb
- Artificial teeth
- Bandages
- Birth control pills
- Body scan
- Braille books and magazines
- Breast pumps and supplies
- Breast reconstruction surgery
- Capital expenses (improvements or special equipment installed to a home, if meant to accommodate a disabled condition)
- Car modifications or special equipment installed for a person with a disability
- Chiropractor
- Christian Science practitioner



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Flexible Spending Account Eligible Expenses

- Contact lenses
- Crutches
- Dental treatment (not including teeth whitening)
- Diagnostic devices
- Disabled dependent care expenses
- Drug addiction treatment
- Eye exam
- Eye glasses
- Eye surgery
- Fertility enhancement (in vitro fertilization or surgery)
- Guide dog or other service animal
- Health institute fees (if treatment is prescribed by a physician)
- Intellectually or developmentally disabled care, treatment or special home
- Laboratory fees
- Lactation expenses
- Lead-based paint removal (if a child in the home has lead poisoning)
- Learning disability care or treatment
- Legal fees associated with medical treatment
- Lifetime care, advance payments or “founder’s fee”
- Lodging at a hospital or similar institution
- Medical conference expenses, if the conference concerns a chronic illness of yourself, your spouse or your dependent
- Medical information plan
- Medications, if prescribed
- Nursing services
- Operations
- Optometrist
- Organ donors
- Osteopath
- Oxygen
- Physical examination
- Pregnancy test kit
- Prosthesis
- Psychiatric care
- Psychoanalysis
- Psychologist
- Special education
- Sterilization
- Stop-smoking programs
- Surgery



**KNOW
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BENEFITS.**

Flexible Spending Account Eligible Expenses

- Special telephone for hearing-impaired individual
- Television for hearing-impaired individuals
- Therapy received as medical treatment
- Transplants
- Transportation for medical care
- Tuition for special education
- Vasectomy
- Vision correction surgery
- Weight-loss program if it is a treatment for a specific disease
- Wheelchair
- Wig
- X-ray

Source:

www.irs.gov/publications/p502/ar02.html#en_US_publink1000178947



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BENEFITS.**

BASIC LIFE / ACCIDENTAL DEATH & DISMEMBERMENT

Reliance Standard

Basic Life/AD&D

Dallas County provides full-time employees with Basic Life/Accidental Death and Dismemberment coverage, and pays the full cost of this benefit. Contact your Human Resources department to update your beneficiary information.

Plan Overview

Basic Benefit Amount

\$35,000

Accidental Death Benefit

Amount is the same as the Basic Life amount.

Living Care Benefits

If you have a qualifying medical condition, you may apply for an accelerated benefit to receive a portion of your life insurance once *during your lifetime*. Amount of benefit: Up to 75% of the Life Insurance in force.

Conversion

Must apply for conversion within 31 days of termination of policy.

Age Reduction Schedule

Coverage reduces by 50% at age 70;

Benefits terminate at retirement

VOLUNTARY TERM LIFE INSURANCE

Reliance Standard

Employees who want to supplement their group life insurance benefits may purchase additional coverage. When you enroll yourself, you may also elect coverage on your dependents in this benefit, you pay the full cost through payroll deductions.

Voluntary Coverage Amounts	
Employee may elect up to 5 times his/her annual salary	
Minimum:	\$10,000
Maximum:	\$500,000
Multiples of:	\$10,000
Spouse may be covered for up to 100% of the Employee amount	
Minimum:	\$10,000
Maximum:	\$100,000
Multiples of:	\$10,000
Child(ren)	
Live birth to 6 months:	\$1,000
Age 6 months to 19 years:	\$10,000 (to age 26 if a full-time student)
Guarantee Issue Amounts⁽¹⁾	
Employee:	5 times annual salary, up to \$150,000
Spouse:	100% of the Employee amount, up to \$30,000
Child(ren):	\$10,000
Accidental Death Benefit	
Amount is the same as the Voluntary coverage amount.	
Portability	
Apply for within 31 days of termination.	
Age Reduction Schedule	
Coverage reduces by 35% at age 70;	
Coverage reduces an additional 20% at age 75.	

⁽¹⁾The levels of Guarantee Issue (GI) coverage are available for employees & family members when the employee is initially eligible. At later annual enrollment periods, all applications for coverage are subject to approval by the carrier.

Employee Monthly Cost per \$1,000 of Employee & Spouse Life/AD&D Benefit											
Age	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Life	\$0.06	\$0.08	\$0.09	\$0.14	\$0.21	\$0.43	\$0.67	\$0.79	\$1.39	\$3.34	\$12.89
AD&D	\$0.035 per \$1,000										
Child(ren)	\$0.19 per \$1,000 (per Dependent Unit)										

Note: Spouse rates are based on the Employee's age.

VOLUNTARY SHORT TERM DISABILITY INSURANCE

Reliance Standard

Short Term Disability Income Benefits

Dallas County provides full-time employees with the opportunity to purchase short term disability income benefits. Employees pay the full cost through payroll deductions. In the event you become disabled from a non-work-related injury or sickness, disability income benefits are provided as a source of income. You are not eligible to receive short-term disability benefits if you are receiving workers' compensation benefits.

Plan Overview	
Benefits Begin	15 th Day Accident/Injury 15 th Day Sickness/Pregnancy
Maximum Benefit Period	15 Weeks
Benefit Amount	60% of Weekly Earnings
Maximum Benefit Amount	\$1,500 per week
Pre-existing Condition Waiting Period	<p>The Policy will not cover any total or partial disability:</p> <ol style="list-style-type: none"> 1. which is caused or contributed to by, or results from a pre-existing condition; and 2. which begins in the first 12 months after the insured employee's effective date. <p>"Pre-Existing Condition" means a sickness or injury for which the insured employee received treatment within 3 months prior to their effective date.</p> <p>"Treatment" means consultation, care or services provided by a physician. It includes diagnostic measures and the prescription, refill of prescription, or taking of any prescribed drugs or medicines.</p>

Employee Monthly Cost per \$10 of Weekly Short Term Disability Benefit											
Age	18-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
Life	\$0.51	\$0.59	\$0.59	\$0.48	\$0.47	\$0.55	\$0.71	\$0.84	\$0.94	\$1.14	\$1.38

Note: Evidence of Insurability is required for late entrants, which will be reviewed by Reliance Standard. Short Term Disability benefits will not be effective until approval from Reliance Standard is received.

LONG TERM DISABILITY INSURANCE

Reliance Standard

Long Term Disability Income Benefits

Dallas County provides full-time employees with long term disability income benefits, and pays the full cost of this coverage. In the event you become disabled, disability income benefits are provided as a source of income.

Plan Overview	
Elimination Period	120 calendar days
Benefit Amount	66.67% of monthly earnings
Maximum Benefit Amount	\$6,500 per month
Maximum Benefit Period	Varies based on the age disability occurs. Refer to your summary plan description for details.
Definition of Disability	24 months Own Occupation
Survivor Benefit	3 months
Pre-Existing Condition Waiting Period	<p>The Policy will not cover any total or partial disability:</p> <ol style="list-style-type: none"> 3. which is caused or contributed to by, or results from a pre-existing condition; and 4. which begins in the first 12 months after the insured employee's effective date. <p>"Pre-Existing Condition" means a sickness or injury for which the insured employee received treatment within 3 months prior to their effective date.</p> <p>"Treatment" means consultation, care or services provided by a physician. It includes diagnostic measures and the prescription, refill of prescription, or taking of any prescribed drugs or medicines.</p>

TRAVEL ASSISTANCE: DESCRIPTION OF COVERED SERVICES

The following is a detailed Description of Covered Services. All services in connection with Emergency Evacuation, Medically Necessary Repatriation, Repatriation of Mortal Remains, Visit by Family Member or Friend, Traveling Companion Transportation and Return of Dependent Children are subject to a maximum Combined Single Limit of Two Hundred Fifty Thousand dollars (\$250,000) per event. Vehicle Return is subject to a sub-limit per event, as listed.

Your assistance services are available when traveling 100 or more miles from your primary residence, or when traveling in a foreign country.

All services must be provided by On Call International (On Call). No claims for reimbursement will be accepted. Any expenses associated with these services are your responsibility except as provided within this Description of Covered Services.

MEDICAL ASSISTANCE SERVICES

Medical Referrals: On Call will assist you in finding Physicians, dentists, and medical facilities.

Medical Monitoring: During the course of a medical emergency, On Call's professional case managers, including Physicians and nurses, will make sure the appropriate level of care is maintained or determine if further intervention, medical transportation, or possibly repatriation (return to U.S.) is needed. On Call will provide case notification, both foreign and domestic, between the patient, family, Physician, employer, travel company, and consulate as needed. On Call will continue to provide all necessary international claim coordination, to include hospital bill translation and interpretation, as needed.

Emergency Medical Payments: When it is necessary for you to obtain needed medical services, upon request, On Call will advance in local currency, up to \$10,000 to cover on-site medical expenses. The advance of funds will be made to the medical provider after On Call has secured funds from you or your family.

Replacement of Medication and Eyeglasses: On Call will arrange to fill a prescription that has been lost, stolen, or requires a refill, subject to local law, whenever possible. On Call will also arrange for shipment of replacement eyeglasses. Costs for shipping of medication or eyeglasses, or a prescription refill, etc., are your responsibility.

Hotel Convalescence Arrangements: On Call can assist you with hotel arrangements if you or your companion needs to convalesce in a hotel prior to or following medical treatment.

Medical Insurance Assistance: On Call can assist you by coordinating notifications to medical insurers or managed care organizations, verifying policy enrollment, confirming medical benefits coverage, guaranteeing medical payments, assisting in the coordination of multiple insurance benefits, and handling claims paperwork flow.

Prescription Drug Assistance: When permitted by law and approved by the patient's Physicians, On Call will assist you in obtaining prescription drugs and other necessary personal medical items that may have been forgotten, lost or depleted while traveling.

EMERGENCY TRANSPORTATION SERVICES

Emergency Evacuation: If you or your dependent suffer an Injury or Sickness and adequate medical facilities are not available locally in the opinion of On Call's Medical Director, On Call will provide emergency evacuation (under medical supervision if necessary) by whatever means necessary to the nearest facility capable of providing adequate care. Services include arranging and paying for transportation and related medical services (including cost of medical escort) and medically necessarily incurred in connection with the emergency evacuation.

Medically Necessary Repatriation: After initial treatment and stabilization for an Injury or Sickness, if the attending Physician and On Call's Medical Director deem it medically necessary, On Call will transport you back to your permanent place of residence for further medical treatment or to recover. Services include arranging and paying for transportation and related medical services (including escort, if necessary) and medical supplies necessarily incurred in connection with the repatriation.

Repatriation of Mortal Remains: In the event of your death, On Call will render assistance and provide for the return of mortal remains. Services include arranging and paying for the following: location of a sending funeral home; transportation of the body from the site of death to the sending funeral home to the airport; minimally necessary casket or air tray for transport; coordination of consular services (in the case of death overseas); procuring death certificates (3 maximum); and transport of the remains from the airport to the receiving funeral home. Other services that might be performed in conjunction with those listed above include: making travel arrangements for any traveling companions; identification and/or notification of next-of-kin.

Visit by Family Member or Friend: If you are hospitalized for more than seven (7) days and are traveling alone, On Call will arrange and provide your family member or friend with transportation to visit you. Visit by Family Member or Friend services includes coverage for meals and accommodations for up to 10 days.

Traveling Companion Transportation: If your travel companion loses previously made travel arrangements due to your medical emergency, On Call will arrange and pay for your traveling companion's return home by the most direct and economical route.

Return of Dependent Children: If you are hospitalized for more than seven (7) days, On Call will arrange and pay for the return of your minor children who are under the age of twenty (20) years of age (or full-time students under the age of twenty-six (26)), and if necessary, accompany him/her with an attendant.

Vehicle Return: In the event of an Emergency Evacuation, Medically Necessary Repatriation, or Repatriation of Mortal Remains, On Call will arrange and return your non-commercial vehicle that is left behind unattended, up to the maximum coverage limit of \$2,500.

LEGAL ASSISTANCE

Locating Legal Services: On Call can assist in contacting a local attorney or the appropriate consular officer if you are arrested or detained, involved in an automobile accident, or otherwise need legal help. On Call will maintain communications with you, your family, and employer until legal counsel has been retained by you.

Bail Bond Services: On Call can assist in securing bail bond services in all available locations.

BAGGAGE ASSISTANCE

On Call can assist you if your baggage is lost, stolen, or delayed while traveling on a common carrier. On Call will advise you of the proper reporting procedures and will help you maintain contact with the appropriate companies or authorities to help resolve the problem.

EMERGENCY PAYMENT ASSISTANCE

On Call can assist you in obtaining an advance of funds for medical expenses or other travel emergencies by coordinating directly with your family, or your credit card company, bank, employer, plan sponsor or other sources of credit.

PRE-TRIP ASSISTANCE – *available at anytime, not subject to 100-mile travel requirement.*

- **Passport and Visa Information:** On Call can advise you of the required documentation to enter and depart foreign destinations.
- **Health Hazards Advisory:** On Call can provide you with up-to-date travel advisories.
- **Inoculation Requirements:** Medical entry requirements can be provided to you prior to your departure.
- **Weather Information:** On Call maintains current information regarding weather conditions for both domestic and international travel destinations. This information will be provided to you through the On Call Assistance Center.
- **Currency Exchange Information:** On Call can provide you with the daily currency exchange rate for a specified country.
- **Consulate and Embassy Locations:** On Call maintains a complete listing of consulates and embassies. These locations are accessible to you by calling the On Call Assistance Center.
- **Translation and Interpreter Services:** Professional translators and interpreters can be reached 24 hours a day to obtain translation or interpreter assistance services during emergency situations while traveling internationally.
- **Travel Locator Service:** You can contact the On Call Assistance Center 24 hours a day, seven (7) days a week, for assistance in locating hotels, airports, sports facilities, campgrounds, and tourist attractions.

EMERGENCY MESSAGE ASSISTANCE

On Call can record emergency messages from you or emergency messages for you for 24-hour periods. These messages may be retrieved at anytime by you, your family, or business associates.

EMERGENCY CASH ASSISTANCE

On Call can assist you with emergency cash up to \$500. Arrangements will be made through a friend, family member, business, or your credit card in the event of an emergency. All fees associated with the transfer or deliveries of funds are your responsibility.

EMERGENCY TICKET REPLACEMENT

On Call can assist you in replacing lost or stolen airline tickets.

EMERGENCY CARD REPLACEMENT

On Call can assist you with emergency card replacement if you should experience a loss, theft, or damage to your credit card or membership card.

EXCLUSIONS AND LIMITATIONS

- A. On Call shall not provide services enumerated if the coverage is sought as a result of: Suicide or attempted suicide; intentionally self-inflicted injuries; participation in any act of war, invasion, acts of foreign enemies, hostilities (whether war is declared or not), civil war, rebellion, revolution, and insurrection, military or usurped power; participation in any military maneuver or training exercise; traveling against the advice of a Physician; traveling for the purpose of obtaining medical treatment; traveling in any country in which the U.S. State Department issued travel restrictions; the commission of or attempt to commit an unlawful act; being under the influence of drugs or intoxicants unless prescribed by a Physician; pregnancy and childbirth (except for complications of pregnancy); mental or emotional disorders, unless hospitalized; participation as a professional in athletics; services provided for you for which no charge is normally made; or travel within 100 miles of your permanent residence, unless in a foreign country.
- B. The services described above currently are available in every country of the world. Due to political and other situations in certain areas of the world, On Call may not be able to respond in the usual manner. It is your responsibility to inquire whether a country is "open" for assistance prior to your departure and during your stay. On Call also reserves the right to suspend, curtail or limit its services in any area in the event of rebellion, riot, military uprising, war, terrorism, labor disturbance, strikes, nuclear accidents, acts of God or refusal of authorities to permit On Call to fully provide services.
- C. If you request a transport related to a condition that has not been deemed medically necessary by a Physician designated by On Call in consultation with a local attending Physician or to any condition excluded hereunder, and you agree to be financially responsible for all expenses related to that transport, On Call will arrange but not pay for such transport to a medical facility or to your residence and will make such arrangements using the same degree of care and completeness as if On Call was providing service under this agreement. A waiver of liability will be required prior to arranging these transportation services.
- D. If you are not eligible and services are provided to you, you may be responsible for the charges incurred.

All transportation benefits provided hereunder must be by the most direct and economical route possible.

For the purposes of this Agreement, the following definitions shall apply; "*Injury*" means identifiable injury caused by an Accident. "*Accident*" means a sudden, unexpected, unusual, specific event, which occurs at an identifiable time and place. "*Sickness*" means a sickness of the Participant which declares itself during the period when services are available under this Agreement.

On Call is not responsible and cannot be held liable for any malpractice performed by a local Physician or attorney who is not an employee of On Call.

2020 MONTHLY PREMIUMS

Coverages	Employee Pays
Employee	
Medical:	\$25.83
Dental:	\$0.00
Vision:	\$0.00
Two Employee Family	
Medical:	\$142.63
Dental:	\$13.69
Vision:	\$4.46
Family	
Medical:	\$245.96
Dental:	\$27.40
Vision:	\$10.58
Voluntary Life/AD&D	Refer to rate table on page 33
Voluntary Short Term Disability	Refer to rate table on page 34
	Employer Pays
Life/AD&D	100% paid by Dallas County
LTD	100% paid by Dallas County

IMPORTANT NOTICE FROM DALLAS COUNTY ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Dallas County and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Dallas County has determined that the prescription drug coverage offered by the Wellmark Blue Shield plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Dallas County coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Dallas County coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Dallas County and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage Dallas County changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	July 1, 2020
Name of Entity/Sender:	Dallas County
Contact--Position/Office:	Beth Deardorff--Director of Human Resources
Address:	902 Court Street, Adel, IA 50003
Phone Number:	(515) 993-1751

HIPAA SPECIAL ENROLLMENT NOTICE

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage (including Medicaid and State Child Health Coverage)

If you are declining coverage for yourself or your dependents (including spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). Some plans may allow longer than 30 days, so please refer to your plan documents for your specific plan details.

Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this health plan.

Marriage, Birth, or Adoption

If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption. Some plans may allow longer than 30 days, so please refer to your plan documents for your specific plan details.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or State Child Health Coverage

If you or your dependents lose eligibility for coverage under Medicaid or State Child Health Coverage Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

WOMEN'S HEALTH & CANCER RIGHTS ACT OF 1998

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications at all stages of the mastectomy, including lymph edemas.

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under this plan.

NEWBORNS' AND MOTHER'S HEALTH PROTECTION ACT

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

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Beginning in 2014, there is a new way to buy health insurance: the **Health Insurance Marketplace**. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Each year, the open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the previous year. After Dec. 15, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent (as adjusted each year after 2014) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or Beth Deardorff at 515-993-1751

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

CUSTOMER SERVICE CONTACT INFORMATION

Refer to this list when you need to contact one of your benefit vendors. For general information contact Human Resources.

MEDICAL:

Wellmark Blue Cross Blue Shield
(800) 524-9242
www.wellmark.com

DENTAL:

Wellmark Blue Dental
(877) 333-0164
www.wellmark.com

VISION:

Avesis
(800) 828-9341
www.avesis.com

FLEXIBLE SPENDING ACCOUNTS (FSA):

Take Care by WageWorks
(800) 950-0105
www.takecarewageworks.com

LIFE/AD&D / SHORT- AND LONG-TERM DISABILITY:

Reliance Standard
(800) 351-7500
www.reliancestandard.com

For additional assistance, contact:

HOLMES MURPHY & ASSOCIATES:

Rachel Pfundstein
(800) 247-7756, ext. 6909
rpfundstein@holmesmurphy.com

Kim Birkelund
(800) 247-7756, ext. 7031
kbirkelund@holmesmurphy.com

Holmes Murphy & Associates has assembled the finest staff of benefits professionals whose expertise is matched by their intelligence and integrity. We further arm them with continuous education, training, and cutting-edge technical resources. These highly specialized consultants have helped us build our reputation for excellence and fuel our growth.



The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide 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 Guide 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. If you have any questions about your Guide, please refer to your Employee Manual for additional information or contact your benefits manager.



Your hearing health care program - for life

Brought to you by Holmes Murphy

We offer...



Custom hearing solutions - we find the solution that best fits your lifestyle and your budget from one of our IO manufacturers.



Risk-free 60-day trial - 100% money-back guarantee.



Continuous Care - one year free follow-up care, two years free batteries, and a three-year warranty.



Hearing aid low price guarantee - if you find the same product at a lower price, bring us the local quote and we'll not only match it, we'll beat it by 5%!

Accessing your discount is as easy as...



Call Amplifon at **1-866-349-9054** and we'll find a provider near you.



We'll explain the Amplifon process and help you schedule an appointment.



We'll send information to you and the provider, ensuring your discount is activated.

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2938MISC/Avesis

www.amplifonusa.com

amplifon Hearing Health Care. **Discount Card**

- Discounted hearing testing
- Low price guarantee
- 60-day risk-free trial period
- 2 years batteries with purchase

To activate your discount, call **1-866-349-9054** today!

Free Hearing Screening offer!

Call **1-866-349-9054** today!

Act now!

*This is not a medical exam and is only intended to assist with amplification selection. Please bring this offer with you to your appointment.

©2017 Amplifon Hearing Health Care, Corp.
2938MISC/Avesis

Employee Name (First, Last)	Social Security Number / Tax Identification Number
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D. Members/enrollees Covered If you need to list more than four dependents, please write all necessary information on a separate sheet of paper and attach to this application. Your employer determines eligibility for coverage. Please confirm with your employer that the dependent types listed below are eligible.

	Name (First, MI, Last)	Date of Birth (mm/dd/yyyy)	Social Security Number/Tax Identification Number ¹	Gender	FT Student? ²	Disabled? ²
<input type="checkbox"/> Spouse		/ /	a. <input type="checkbox"/> SSN/TIN _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	N/A	<input type="checkbox"/> Yes
<input type="checkbox"/> Dependent		/ /	a. <input type="checkbox"/> SSN/TIN _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> Dependent		/ /	a. <input type="checkbox"/> SSN/TIN _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> Dependent		/ /	a. <input type="checkbox"/> SSN/TIN _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> Dependent		/ /	a. <input type="checkbox"/> SSN/TIN _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

¹The IRS requires Wellmark to collect SSNs/TINs for federal reporting purposes. Your employer will follow up with you to collect this information if you do not complete a., b., or c. for each person listed. Failure to provide the SSN/TIN information may result in a \$50 penalty, per violation, assessed to you by the IRS.

²If your plan covers dependent(s) age 26 or older, they must be unmarried and either a full-time student or a disabled dependent. Please contact your Wellmark representative for more information.

E. Medicare Coverage (Required)

Yes No Are you and/or anyone listed in Section D Social Security disabled?
If yes, list names _____

Yes No Are you and/or anyone listed in Section D enrolled in Medicare?
If yes, complete as appropriate:

Employee Name (as it appears on Medicare card)	Medicare ID
--	-------------

Effective Date (Part A) ____/____/____	Effective Date (Part B) ____/____/____
--	--

Spouse Name (as it appears on Medicare card)	Medicare ID
--	-------------

Effective Date (Part A) ____/____/____	Effective Date (Part B) ____/____/____
--	--

Dependent Name (as it appears on Medicare card)	Medicare ID
---	-------------

Effective Date (Part A) ____/____/____	Effective Date (Part B) ____/____/____
--	--

Employee Name (First, Last)	Social Security Number / Tax Identification Number
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F. Other Carrier Information (Required)

Yes No Will you, your spouse, or your dependents keep other health coverage in addition to this Wellmark, Inc. coverage?

If yes, please complete the following:

Policyholder Name (First, Last) _____ Date of Birth ____/____/____

Please list those covered by the other health plan(s) _____

Policy No. _____ Effective Date ____/____/____

Employer Name (if coverage is through employer group) _____

Insurance Company/HMO Name _____

Address Line 1 (Street Address or Suite#) _____

Address Line 2 (PO Box, Street Address) _____

City _____ State _____ ZIP _____

Phone Number (_____) _____

Is there a divorce decree/court order that requires one parent to provide health insurance coverage for any dependent?

Yes No If yes, please complete the following:

List dependent(s) _____

List name of person required to provide health insurance _____

List name of person who has primary physical custody _____

G. Waiver of Enrollment (Please complete if you are waiving health or dental benefits.)

I waive health coverage for my dependents and myself. Please indicate one of the following reasons:

- I (We) have coverage under another health care benefit plan.
- I (We) do not wish to enroll in the health plan.

I waive Blue Dental coverage for my dependents and myself. Please indicate one of the following reasons:

- I (We) have coverage under another dental plan.
- I (We) do not wish to enroll in the Blue Dental plan.

Please see Section H: Important Information Regarding Waiver of Enrollment.

H. Important Information Regarding Waiver Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within a period of time specified by your employer after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within the time specified by your employer after the marriage, birth, adoption, or placement for adoption. Additionally, you must enroll within the time specified by your employer after you lose eligibility for coverage under Medicaid or CHIP or become eligible for Medicaid or CHIP premium assistance.

Please note that if you or your dependents are not covered by minimum essential coverage, you may be responsible for individual shared responsibility payments when filing your federal income tax return. Also, by declining the coverage offered by your employer, you or your dependents may not be eligible for Marketplace coverage subsidies.

To request special enrollment or obtain more information, refer to your Summary Plan Description (SPD), coverage manual, other benefits documents, or contact your employer.

Employee Name (First, Last)	Social Security Number / Tax Identification Number
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I. Authorization and Certification

I certify that I am legally authorized to apply for coverage for myself and all other persons named in this application. I understand that I am completing this application for the coverage sponsored by my employer or group sponsor and offered by Wellmark, Inc., doing business as Wellmark Blue Cross and Blue Shield of Iowa, or Wellmark Health Plan of Iowa, Inc. (each referenced herein as "Wellmark").

I certify that, after this application was completed, I carefully and fully read it, that the statements and answers set forth are full, true, and correct to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that my employer or group sponsor will rely on the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or concealed any material fact, my employer or group sponsor is entitled to declare the contracts applied for void and to refuse allowance on benefits to any person thereunder. I understand and grant authorization for my employer, group sponsor, consultant, or Wellmark agent to electronically submit the information provided by me on this signed application for enrollment purposes.

I acknowledge I have received or have been advised and understand I will receive from my employer the Summary of Benefits and Coverage (SBC).

Providing Social Security Numbers or Tax Identification Numbers

Wellmark requires Social Security numbers or other tax identification numbers for federal reporting purposes. If Wellmark does not have Social Security or tax identification numbers for each enrollee, Wellmark or my employer may be unable to report and send information needed to complete federal tax returns. If Social Security numbers or tax identification numbers are not provided for all individuals covered, Wellmark or my employer may contact the primary policyholder to obtain the information. If I do not provide the Social Security numbers or tax identification numbers for these purposes, I may be subject to a monetary penalty imposed by the internal revenue service.

HSA Coverage

In the event I have selected a High Deductible Health Plan, I understand that enrolling in such coverage does not guarantee that I am or will be eligible to make contributions to an HSA or that contributions can be made to an HSA on my behalf.

Release of Medical Information

I authorize any health care provider, including but not limited to; surgeon, physician, psychologist, nurse, social worker, or health care facility to release to Wellmark all health and mental health records, including those records protected by Federal or State law relating to AIDS or AIDS related complex, mental health and substance abuse, the past, present, or future treatments or conditions for myself or for my dependents eligible for health care coverage. I understand that I have the right to revoke this authorization in writing at any time by delivering such written notification to the requestor. I understand that a revocation is not effective until received by the requestor. I further understand that any revocation is not effective to the extent that Wellmark or Provider have relied on it in the use or disclosure of protected health information.

This form does not authorize the redisclosure of medical information. Federal and State regulations do not allow further disclosure of mental health, substance abuse and AIDS/HIV related information. Wellmark maintains the confidentiality of all information received and it will not be released to any person or facility.

The protected health information described above may be disclosed to and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

I understand that I have the right to refuse to sign this authorization, but that Wellmark will then have the right to condition eligibility determination and enrollment on the receipt of this signed authorization.

I have read and understand the Important Information Regarding Waiver of Enrollment and Authorization and Certification language on this application and acknowledge receipt of a fully completed copy of this application.

Employee Signature _____ **Date** ____/____/____



60790-6366

I am Waiving Vision Insurance

AVESIS ADVANTAGE VISION CARE EMPLOYEE ENROLLMENT FORM

PLEASE PRINT LEGIBLY

Underwritten by Fidelity Security Life Insurance Company Kansas City, Missouri

001y 000C-0600C-23

TO BE COMPLETED BY THE EMPLOYEE

Employee Last Name				Employee First Name				MI
Date of Birth / /		Social Security Number - -			Sex <input type="checkbox"/> Male <input type="checkbox"/> Female			
Street Address							Apartment No.	
City				State	Zip Code -			

Do you wish to cover your eligible dependents? Yes No

If yes, complete the following:

	Dependent Name		Date of Birth
	FIRST	LAST	
Spouse / Domestic Partner			/ /
Child			/ /

I would like to cover additional eligible dependents LAST LIST A SECOND ROLLMENT FORM

I authorize deductions from my earnings at the required contributions towards the cost of the coverage

Signature	Date / /
-----------	-------------

A-00703

M-9059/M-9069/M-9006

TO BE COMPLETED BY THE EMPLOYER

<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Add ○ Dependents	<input type="checkbox"/> Change ○ Address ○ None ○ Rate ○ COBRA	<input type="checkbox"/> Cancel Coverage ○ Voluntary Rider ○ Dependents
Reason for Change	<input type="checkbox"/> Employment Status <input type="checkbox"/> Qualifying Event <input type="checkbox"/> LAST STATE <input type="checkbox"/>		
Requested Effective Date / /	Date of Employment / /		

**Reliance Standard Life Insurance Company
Enrollment and Statement of Health**

Name of Employer Dallas County		Location/Division		Bill Group 000001
Policy # and Class # GL154077 / 1	Policy # and Class # VAR206597 / 1	Policy # and Class #	Policy # and Class #	Policy # and Class #

Application Type: Initial Eligibility/New Hire Late Applicant Other _____
 Increase Approved Annual Enrollment
 Change in Status: Nature of Change(s): _____

Date of Change: _____
 If marriage, divorce or birth of a child, please provide copy of document.

Employee/Member Information – Always Complete

Submit completed Enrollment and Statement of Health form to:
EOIApplications@rsli.com or

**Reliance Standard
P.O. Box 7818
Philadelphia, PA 19101-7818**

We do not accept faxed forms.

Name			Social Security Number		
Gender	Date of Birth	Age	State of Birth	Date of Hire	
Address			City	State	Zip
Phone Number	Occupation	Annual Compensation	Hours Worked Per Week		
Email Address					

Are you actively performing all the duties of your occupation or profession? Yes No

If "No," explain: _____

Spouse Information – Complete Only If Applying for Spouse Coverage

Spouse Name	Gender	Date of Birth	Age	State of Birth
Address	City	State	Zip	

Coverage Elected and Amounts

Coverage	Enroll or Decline ¹	Current Amount	Increase or Decrease	Total Amount Applied For	Monthly Premium
Group Term Supplemental Life Employee²	<input type="checkbox"/> Enroll <input type="checkbox"/> Decline			<input type="checkbox"/> \$150,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$80,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/> Other\$ _____	See Premium Table
Group Term Life: Spouse^{2,3}	<input type="checkbox"/> Enroll <input type="checkbox"/> Decline			<input type="checkbox"/> \$30,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> Other\$ _____	See Premium Table
Group Term Life: Dep. Children³	<input type="checkbox"/> Enroll <input type="checkbox"/> Decline			<input type="checkbox"/> \$10,000	\$1.90
Voluntary AD&D: Employee	<input type="checkbox"/> Enroll <input type="checkbox"/> Decline			\$ _____	See Premium Table
Voluntary AD&D: Spouse	<input type="checkbox"/> Enroll <input type="checkbox"/> Decline			\$ _____	See Premium Table

¹"Enroll" authorizes employer to payroll deduct premiums.

²Statement of Health may be required.

³Coverage subject to election of employee coverage.

Employee/Member Name	Date of Birth
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Health Questions

Answer all questions on this page for each person being underwritten for insurance. For any "Yes" answer, underline the condition and record details in the space provided on the next page. Failure to provide details of a condition will cause a delay in the review of your application.

	EMPLOYEE	SPOUSE
Enter height and weight.	Ht. ___ft. ___in. Wt. _____ lbs	Ht. ___ft. ___in. Wt. _____ lbs
<input type="checkbox"/> In the past 10 years, have you or your spouse been treated for or diagnosed as having: heart, liver (biliary cirrhosis) or kidney disorder; an abnormal colonoscopy requiring follow-up; neurological disorder; diabetes; high blood pressure; thyroid disorder; stroke; transient ischemic attack (TIA); cancer and/or tumor malignant or benign; mental or nervous disorder; or been advised to have treatment for drug abuse (illegal or prescription drugs) or alcoholism?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> In the past 10 years, have you or your spouse been diagnosed with or treated for: chronic pain; arthritis (lupus, rheumatoid or osteoarthritis); musculoskeletal (back, neck or muscle) condition; respiratory disorder including asthma, chronic obstructive pulmonary disease (COPD); or emphysema?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Have you or your spouse: (a) in the past year had: fever persisting more than one month; significant involuntary weight loss; diarrhea persisting more than one month; oral candidiasis (thrush); or lymphadenopathy (enlarged or swollen glands)? or (b) in the past 10 years ever tested positive or been treated for HIV (Human Immunodeficiency Virus) antibodies, AIDS or AIDS-related complex (ARC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> In the past 10 years, have you or your spouse: (a) consulted with or been examined or treated by a physician, practitioner or specialist (include routine physicals only when there is an existing or newly diagnosed medical condition)? (b) been in a hospital or other facility for observation, diagnosis, treatment or an operation? or (c) been prescribed medication(s) (other than for colds, flu or allergies)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Are you currently pregnant? In the past 10 years, have you or your spouse been diagnosed with: abnormal uterine bleeding; abnormal pap smear; abnormal mammogram requiring additional studies or with recommendation of breast biopsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Employee/Member Primary Care Physician's Full Name	Office Phone Number
Address	
Spouse Primary Care Physician's Full Name	Office Phone Number
Address	

Employee/Member Name	Date of Birth
----------------------	---------------

Details

Please provide all names used for medical records and different than the names provided on this form.

For each "Yes" response to a health question, please provide details below.

Question #	Illness or Nature of Injury	Date	Physician's Full Name and Address (if different than Primary)	Check One Employee or Spouse	

If you need more space, check here. Complete, sign and date a separate sheet of paper and attach it to this page.

Read, Sign and Date Below

- I understand and agree that:
- The information provided on this Enrollment and Statement of Health form is true and correct to the best of my knowledge.
 - The insurance requested will become effective in accordance with the individual effective date information in the Policy; any amount subject to evidence of insurability will not become effective until approved by Reliance Standard and Reliance Standard has the right to refuse my request. Coverage is subject to a minimum participation requirement at the employer level and if the minimum is not met, coverage may not be issued even though an enrollment form has been completed. An effective date is subject to eligibility requirements, satisfaction of service waiting period (if applicable) and payment of first premium when due. An effective date may be deferred for an employee not actively at work and enrolled dependents confined to a hospital or at home.
 - Benefits are subject to terms and conditions of the Policy.
 - For age-banded rate plans, premiums increase as an employee (or spouse, if applicable) moves from one age band to the next.
 - If payroll deduction of premiums begins prior to Reliance Standard's processing of the enrollment form, it does not mean coverage is in effect; premiums paid for coverage not issued will be returned.

I further understand and agree that if I am applying after the expiration of my initial eligibility period, all medical tests and costs for attending physician reports may be without expense to Reliance Standard Life Insurance Company and I may be responsible for paying the expenses, if any.

I acknowledge receipt of the "Designation of Beneficiary" form and "Important Information Regarding Applications for Insurance" and "Notice Regarding Information Practices". If a Designation of Beneficiary form is not completed or one is not on file with the Plan Administrator, the provisions of the Policy will determine to whom benefits, if any, will be payable.

AUTHORIZATION: I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, organization, institution, person or the MIB, Inc. to release any information or record(s) on me or my health to be used in determining the acceptability of my application for insurance. I authorize any such information or record(s) to be released to Reliance Standard Life Insurance Company, its reinsurers or authorized representatives. I also authorize Reliance Standard or its reinsurers to make a brief report of my personal health information to the MIB. This authorization, or a photographic copy, shall be as binding as the original and valid for a period not exceeding twelve (12) months from this date. I understand that I (or my authorized representative) will be sent a copy of this Authorization upon request.

Please Note: During an approved enrollment, guaranteed issue amounts of insurance will not require a Statement of Health form provided the Enrollment form is complete, signed and received by your employer during your enrollment period and: a) you are not a late applicant with respect to insurance for yourself (and/or your spouse, if applicable); or b) during your present service with your employer or an affiliate, you (and/or your spouse, if applicable,) have not, with respect to insurance with Reliance Standard or an affiliate: had an application withdrawn; been previously declined; had coverage postponed; or voluntarily terminated; or c) the enrollment period is not one with specific guaranteed issue/health acceptability rules.

X _____ Employee's/Member's Signature (required at all times)	_____ Date	X _____ Spouse's Signature (required if spouse Statement of Health required)	_____ Date
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Designation of Beneficiary

Policyholder	Policy Number
Insured Name	Social Security Number

I hereby designate the following as my beneficiary/es under the above policy number/s
Primary Beneficiary(ies)

Full Name and Address (Please Print)	Percentage (Must total 100%)	Date of Birth	Relationship	Social Security Number

No percentages are indicated - benefits will be divided equally between all primary beneficiary/es

Contingent Beneficiary(ies) (applicable only if you are not survived by one or more primary beneficiary/es)

Full Name and Address (Please Print)	Percentage (Must total 100%)	Date of Birth	Relationship	Social Security Number

No percentages are indicated - any benefits payable to contingent beneficiary/es will be divided equally between all contingent beneficiary/es

- ◆ This beneficiary designation replaces all reachable prior beneficiary designations
- ◆ Unless you indicate otherwise, any beneficiary redemptions you elect beneficiary's share will be divided pro-rata among the surviving beneficiary/es of the same class primary or contingent
- ◆ If no beneficiary primary or contingent survives you, payment will be made pursuant to the terms of the applicable policy

Date	Signature of Insured
------	----------------------

Important Information Regarding Applications for Insurance

The information provided on the Enrollment and Statement of Health form will be used in determining the insurability of a person proposed for insurance. Responsible parties completing and submitting a Statement of Health form are required to be made aware of the following statements concerning the consequences of insurance fraud. The lack of an applicable statement shall not constitute a defense against penalties.

ARKANSAS and LOUISIANA — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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. **FLORIDA** — Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. **KENTUCKY** — Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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. **MAINE** — It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. **MARYLAND** — Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who 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. **NEW JERSEY** — Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. **NEW MEXICO** — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefits 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. **NEW YORK** (health insurance only) — 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. **OHIO** — Any person who, with intent to defraud or knowing that he 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. **RHODE ISLAND** — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **TENNESSEE, VIRGINIA, 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. **WASHINGTON, DC** — **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.

KEEP THIS INFORMATION PAGE FOR YOUR RECORDS.

RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

Home Office: Schaumburg, Illinois
Administrative Office: Philadelphia, Pennsylvania

NOTICE REGARDING INFORMATION PRACTICES

In considering this Application, Reliance Standard Life Insurance Company ("we", "us" or "our") collects certain information about all proposed insureds ("you" or "your"). The precise information varies according to the amount and type of coverage you apply for. Generally, we seek information about you: (1) age; (2) occupation; (3) physical condition; (4) medical history; (5) hobbies; and (6) other relevant activities.

You are the most important source of information, but we may also verify or collect information on you or your family from: (1) physicians; (2) other health care providers; (3) employers; (4) other insurers to which you have applied; (5) consumer investigative organizations; and (6) the MIB, Inc.

The MIB is a not-for-profit organization of life insurance companies which operates an information exchange for its members. This information may alert us to a need for further investigation, but under MIB rules such information cannot be used: (1) either wholly or in part to increase the premium for insurance; or (2) to deny issuance of insurance.

We may collect information by: (1) phone; (2) correspondence; or (3) personal contact.

Information will be treated as confidential. Reliance Standard Life Insurance Company or its reinsurers may, however, with your authorization make a brief report to the MIB. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply such company with the information in its file. The information supplied to other member companies may alert them to a need for further investigation.

In some circumstances, however, information may be released to third parties without your authorization (with the exception of the MIB). These include persons or organizations who are: (1) performing business functions for us; (2) conducting actuarial or scientific studies or audits; or (3) our reinsurers. We or our reinsurers may also release information to other life insurance companies to whom you apply for life or health insurance coverage, or to whom a claim for benefits is submitted. Please be assured that although such disclosures may occur, they are not always or even often made. When a disclosure is necessary, only as much information as is reasonably necessary to achieve the intended purpose will be disclosed.

You have the right to acquire and, if necessary, correct any personal information we or the MIB collect. Upon written request to us, we will within 30 days of receipt: (1) inform you of the nature and substance of the recorded information; (2) permit personal viewing and copying of the information in our possession; (3) disclose the identities of those persons such information has been disclosed to within the last two years; and (4) provide you with procedures for correction, amendment or deletion of the recorded information. Medical information will be disclosed to a physician that you choose. You may write to us for a fuller explanation of our information practices.

You may also contact the MIB via its website (www.mib.com) or by telephone to arrange for disclosure of any information it may have on you. The MIB's toll-free telephone number is 866-692-6901. If you question the accuracy of information in the MIB's file, you may contact the MIB in writing and seek correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734.

KEEP THIS NOTICE FOR YOUR RECORDS.

RELiance STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

Home Office: Schaumburg, Illinois
Administrative Office: Philadelphia, Pennsylvania

Employee/Member Name	Date of Birth
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Read, Sign and Date Below

I understand and agree that:

- The information provided on this Enrollment and Statement of Health form is true and correct to the best of my knowledge.
- The insurance requested will become effective in accordance with the individual effective date information in the Policy; any amount subject to evidence of insurability will not become effective until approved by Reliance Standard and Reliance Standard has the right to refuse my request. Coverage is subject to a minimum participation requirement at the employer level and if the minimum is not met, coverage may not be issued even though an enrollment form has been completed. An effective date is subject to eligibility requirements, satisfaction of service waiting period (if applicable) and payment of first premium when due. An effective date may be deferred for an employee not actively at work and enrolled dependents confined to a hospital or at home.
- Benefits are subject to terms and conditions of the Policy.
- For age-banded rate plans, premiums increase as an employee moves from one age band to the next.
- If payroll deduction of premiums begins prior to Reliance Standard's processing of the enrollment form, it does not mean coverage is in effect; premiums paid for coverage not issued will be returned.

I further understand and agree that if I am applying after the expiration of my initial eligibility period, all medical tests and costs for attending physician reports may be without expense to Reliance Standard Life Insurance Company and I may be responsible for paying the expenses, if any.

I acknowledge receipt of "Important Information Regarding Applications for Insurance".

Please Note: During an approved enrollment, guaranteed issue amounts of insurance will not require a Statement of Health form provided the Enrollment form is complete, signed and received by your employer during your enrollment period and: a) you are not a late applicant with respect to insurance for yourself; or b) during your present service with your employer or an affiliate, you have not, with respect to insurance with Reliance Standard or an affiliate: had an application withdrawn; been previously declined; had coverage postponed; or voluntarily terminated; or c) the enrollment period is not one with specific guaranteed issue/health acceptability rules.

X _____ Employee's/Member's Signature (required at all times)	_____ Date
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